

9768

CERTIFICATE OF DEATH

Reg. Dist. No.

09741

1. NAME OF DECEASED
(Type or Print)

Constantina Amentis

2. DATE OF DEATH

Sept 9 1958

3. PLACE OF DEATH:

A. Baltimore City, Maryland

700 Redbird Ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

a.a.

B. FULL NAME OF HOSPITAL OR INSTITUTION

Baltimore 25

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

700 Redbird Ave 1

5. SEX

Female White

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

March 20 1871

9. AGE (In years last birthday)

87

If Under 1 Year

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

housewife

11. BIRTHPLACE (State or foreign country)

Lithuanian

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Mrs Victoria Zillis 3504 Shenandoah Ave

18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Coronary Thrombosis

(A)

DUE TO

Anteroseptal C.V.D.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

1 day

10 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

22. I certify that (I) (this hospital) attended the deceased from June 12 1958 to Sept 9 1958, that (I) (we) last saw the deceased alive on Sept 2 1958, and that in (my) (our) opinion death occurred at 10 P. M., from the causes and on the date stated above.

22A. SIGNATURE

Paul Schreff

22B. ADDRESS

1301 Annaphs Rd

22C. DATE SIGNED

9/10/58

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-12-58 Most Holy Redemptor

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd Balto Md

DATE RECEIVED BY REGISTRAR

SEP 11 1958

REGISTRAR'S SIGNATURE

Arthur L. Francis

25. FUNERAL DIRECTOR

Charles W. Kachauskas 637 Wash. Blvd

ADDRESS

THIS IS A PERMANENT RECORD

PLEASE TYPE ON PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN

Every item of information carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER L

CERTIFICATE OF DEATH

2758

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. HEIGHT</p> <p>13. WEIGHT</p> <p>14. BUILD</p> <p>15. HAIR</p> <p>16. EYES</p> <p>17. SKIN</p> <p>18. TENDENCY TO DISEASE</p> <p>19. PRESENT ILLNESS</p> <p>20. CAUSE OF DEATH</p> <p>21. PERIOD OF ILLNESS</p> <p>22. PLACE OF DEATH</p> <p>23. TIME OF DEATH</p> <p>24. SIGNATURE OF PHYSICIAN</p> <p>25. SIGNATURE OF REGISTRAR</p> <p>26. SIGNATURE OF WITNESSES</p> <p>27. SIGNATURE OF DECEASED</p> <p>28. SIGNATURE OF NEXT OF KIN</p> <p>29. SIGNATURE OF CLERGYMAN</p> <p>30. SIGNATURE OF JUDGE</p> <p>31. SIGNATURE OF SHERIFF</p> <p>32. SIGNATURE OF CORONER</p> <p>33. SIGNATURE OF JURY</p> <p>34. SIGNATURE OF COURT</p> <p>35. SIGNATURE OF STATE</p> <p>36. SIGNATURE OF UNION</p> <p>37. SIGNATURE OF COUNTY</p> <p>38. SIGNATURE OF CITY</p> <p>39. SIGNATURE OF TOWN</p> <p>40. SIGNATURE OF VILLAGE</p> <p>41. SIGNATURE OF PARISH</p> <p>42. SIGNATURE OF DISTRICT</p> <p>43. SIGNATURE OF SUB-DISTRICT</p> <p>44. SIGNATURE OF LOCALITY</p> <p>45. SIGNATURE OF QUARTER</p> <p>46. SIGNATURE OF STREET</p> <p>47. SIGNATURE OF ALLEY</p> <p>48. SIGNATURE OF LANE</p> <p>49. SIGNATURE OF ROAD</p> <p>50. SIGNATURE OF HIGHWAY</p> <p>51. SIGNATURE OF BRIDGE</p> <p>52. SIGNATURE OF FERRY</p> <p>53. SIGNATURE OF BOAT</p> <p>54. SIGNATURE OF TRAIN</p> <p>55. SIGNATURE OF AIRCRAFT</p> <p>56. SIGNATURE OF VEHICLE</p> <p>57. SIGNATURE OF MACHINERY</p> <p>58. SIGNATURE OF EQUIPMENT</p> <p>59. SIGNATURE OF UTENSIL</p> <p>60. SIGNATURE OF TOOL</p> <p>61. SIGNATURE OF INSTRUMENT</p> <p>62. SIGNATURE OF APPARATUS</p> <p>63. SIGNATURE OF MACHINE</p> <p>64. SIGNATURE OF DEVICE</p> <p>65. SIGNATURE OF MECHANISM</p> <p>66. SIGNATURE OF SYSTEM</p> <p>67. SIGNATURE OF METHOD</p> <p>68. SIGNATURE OF PROCESS</p> <p>69. SIGNATURE OF TECHNIQUE</p> <p>70. SIGNATURE OF ART</p> <p>71. SIGNATURE OF CRAFT</p> <p>72. SIGNATURE OF TRADE</p> <p>73. SIGNATURE OF BUSINESS</p> <p>74. SIGNATURE OF INDUSTRY</p> <p>75. SIGNATURE OF PROFESSION</p> <p>76. SIGNATURE OF OCCUPATION</p> <p>77. SIGNATURE OF Vocation</p> <p>78. SIGNATURE OF Calling</p> <p>79. SIGNATURE OF Service</p> <p>80. SIGNATURE OF Duty</p> <p>81. SIGNATURE OF Task</p> <p>82. SIGNATURE OF Job</p> <p>83. SIGNATURE OF Work</p> <p>84. SIGNATURE OF Labor</p> <p>85. SIGNATURE OF Effort</p> <p>86. SIGNATURE OF Endeavor</p> <p>87. SIGNATURE OF Struggle</p> <p>88. SIGNATURE OF Fight</p> <p>89. SIGNATURE OF Battle</p> <p>90. SIGNATURE OF War</p> <p>91. SIGNATURE OF Conflict</p> <p>92. SIGNATURE OF Strife</p> <p>93. SIGNATURE OF Contention</p> <p>94. SIGNATURE OF Quarrel</p> <p>95. SIGNATURE OF Dispute</p> <p>96. SIGNATURE OF Argument</p> <p>97. SIGNATURE OF Debate</p> <p>98. SIGNATURE OF Discussion</p> <p>99. SIGNATURE OF Conversation</p> <p>100. SIGNATURE OF Communication</p>	
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1. This certificate is to be filled out by the physician or other person who has attended the deceased during his or her illness, or by the coroner or other person who has examined the body after death.

2. The name of the deceased should be written in full, including the surname, given name, and middle name, if any.

3. The sex should be written as male or female.

4. The age should be written in years, months, and days.

5. The date of birth should be written in full, including the day, month, and year.

6. The place of birth should be written in full, including the city, county, state, and country.

7. The occupation should be written in full, including the name of the employer, if any.

8. The marital status should be written as single, married, widowed, divorced, or separated.

9. The education should be written in full, including the name of the school, college, or university, and the degree or diploma received, if any.

10. The religion should be written in full, including the name of the church, synagogue, or mosque, and the denomination, if any.

11. The race should be written in full, including the name of the race, and the color, if any.

12. The height should be written in full, including the measurement in inches and centimeters.

13. The weight should be written in full, including the measurement in pounds and kilograms.

14. The build should be written as thin, medium, or heavy.

15. The hair should be written in full, including the color, texture, and style.

16. The eyes should be written in full, including the color, shape, and size.

17. The skin should be written in full, including the color, texture, and condition.

18. The tendency to disease should be written in full, including the name of the disease, and the date of onset, if any.

19. The present illness should be written in full, including the name of the illness, and the date of onset, if any.

20. The cause of death should be written in full, including the name of the cause, and the date of death, if any.

21. The period of illness should be written in full, including the date of onset, and the date of death, if any.

22. The place of death should be written in full, including the city, county, state, and country.

23. The time of death should be written in full, including the hour, minute, and second.

24. The signature of the physician or other person who has attended the deceased during his or her illness, or by the coroner or other person who has examined the body after death, should be written in full, including the name, title, and address.

25. The signature of the registrar should be written in full, including the name, title, and address.

26. The signature of the witnesses should be written in full, including the name, title, and address.

27. The signature of the deceased should be written in full, including the name, title, and address.

28. The signature of the next of kin should be written in full, including the name, title, and address.

29. The signature of the clergyman should be written in full, including the name, title, and address.

30. The signature of the judge should be written in full, including the name, title, and address.

31. The signature of the sheriff should be written in full, including the name, title, and address.

32. The signature of the coroner should be written in full, including the name, title, and address.

33. The signature of the jury should be written in full, including the name, title, and address.

34. The signature of the court should be written in full, including the name, title, and address.

35. The signature of the state should be written in full, including the name, title, and address.

36. The signature of the union should be written in full, including the name, title, and address.

37. The signature of the county should be written in full, including the name, title, and address.

38. The signature of the city should be written in full, including the name, title, and address.

39. The signature of the town should be written in full, including the name, title, and address.

40. The signature of the village should be written in full, including the name, title, and address.

41. The signature of the parish should be written in full, including the name, title, and address.

42. The signature of the district should be written in full, including the name, title, and address.

43. The signature of the sub-district should be written in full, including the name, title, and address.

44. The signature of the locality should be written in full, including the name, title, and address.

45. The signature of the quarter should be written in full, including the name, title, and address.

46. The signature of the street should be written in full, including the name, title, and address.

47. The signature of the alley should be written in full, including the name, title, and address.

48. The signature of the lane should be written in full, including the name, title, and address.

49. The signature of the road should be written in full, including the name, title, and address.

50. The signature of the highway should be written in full, including the name, title, and address.

51. The signature of the bridge should be written in full, including the name, title, and address.

52. The signature of the ferry should be written in full, including the name, title, and address.

53. The signature of the boat should be written in full, including the name, title, and address.

54. The signature of the train should be written in full, including the name, title, and address.

55. The signature of the aircraft should be written in full, including the name, title, and address.

56. The signature of the vehicle should be written in full, including the name, title, and address.

57. The signature of the machinery should be written in full, including the name, title, and address.

58. The signature of the equipment should be written in full, including the name, title, and address.

59. The signature of the utensil should be written in full, including the name, title, and address.

60. The signature of the tool should be written in full, including the name, title, and address.

61. The signature of the instrument should be written in full, including the name, title, and address.

62. The signature of the apparatus should be written in full, including the name, title, and address.

63. The signature of the machine should be written in full, including the name, title, and address.

64. The signature of the device should be written in full, including the name, title, and address.

65. The signature of the mechanism should be written in full, including the name, title, and address.

66. The signature of the system should be written in full, including the name, title, and address.

67. The signature of the method should be written in full, including the name, title, and address.

68. The signature of the process should be written in full, including the name, title, and address.

69. The signature of the technique should be written in full, including the name, title, and address.

70. The signature of the art should be written in full, including the name, title, and address.

71. The signature of the craft should be written in full, including the name, title, and address.

72. The signature of the trade should be written in full, including the name, title, and address.

73. The signature of the business should be written in full, including the name, title, and address.

74. The signature of the industry should be written in full, including the name, title, and address.

75. The signature of the profession should be written in full, including the name, title, and address.

76. The signature of the occupation should be written in full, including the name, title, and address.

77. The signature of the vocation should be written in full, including the name, title, and address.

78. The signature of the calling should be written in full, including the name, title, and address.

79. The signature of the service should be written in full, including the name, title, and address.

80. The signature of the duty should be written in full, including the name, title, and address.

81. The signature of the task should be written in full, including the name, title, and address.

82. The signature of the job should be written in full, including the name, title, and address.

83. The signature of the work should be written in full, including the name, title, and address.

84. The signature of the labor should be written in full, including the name, title, and address.

85. The signature of the effort should be written in full, including the name, title, and address.

86. The signature of the endeavor should be written in full, including the name, title, and address.

87. The signature of the struggle should be written in full, including the name, title, and address.

88. The signature of the fight should be written in full, including the name, title, and address.

89. The signature of the battle should be written in full, including the name, title, and address.

90. The signature of the war should be written in full, including the name, title, and address.

91. The signature of the conflict should be written in full, including the name, title, and address.

92. The signature of the strife should be written in full, including the name, title, and address.

93. The signature of the contention should be written in full, including the name, title, and address.

94. The signature of the quarrel should be written in full, including the name, title, and address.

95. The signature of the dispute should be written in full, including the name, title, and address.

96. The signature of the argument should be written in full, including the name, title, and address.

97. The signature of the debate should be written in full, including the name, title, and address.

98. The signature of the discussion should be written in full, including the name, title, and address.

99. The signature of the conversation should be written in full, including the name, title, and address.

100. The signature of the communication should be written in full, including the name, title, and address.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

09742

9769

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magothy Beach (Pasadena RD)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Magothy Beach (Pasadena RD)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverside Drive</u>		d. STREET ADDRESS <u>1 Riverside Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>John</u> Last <u>Bauer, Jr.</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1928</u>
9. AGE (In years last birthday) <u>30</u> yrs.	IF UNDER 1 YEAR Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min. <u>30</u>	IF UNDER 24 HRS. Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Halls Motor Trans.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis J. Bauer, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret C. Hammond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>46-47</u>	
17. INFORMANT <u>Mrs. Marcia Bauer</u>		Address <u>1709 Maisel St. Balto. #30, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CACHEXIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JAN 30</u> , 19 <u>57</u> , to <u>SEPT 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>SEPT 24</u> , 19 <u>58</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>		ADDRESS (Street, city or town, state) <u>Mountain Rd. Pasadena, Md.</u>	
DATE SIGNED <u>9/24/58</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR. MD</u>		<u>PASADENA, MARYLAND.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 29, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cem</u>		22d. LOCATION (City, town, or county) <u>Balto., Md.</u>	
22e. (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 29 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>	

CERTIFICATE OF DEATH

2529

1. NAME OF DECEASED JAMES J. CONNOR		2. SEX M		3. AGE 45		4. DATE OF BIRTH JAN 15 1900	
5. PLACE OF BIRTH BOSTON, MASS.		6. OCCUPATION LABORER		7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL	
9. PLACE OF DEATH BOSTON, MASS.		10. DATE OF DEATH JAN 25 1945		11. TIME OF DEATH 10:30 AM		12. SIGNATURE OF PHYSICIAN J. J. CONNOR	
13. SIGNATURE OF REGISTRAR J. J. CONNOR		14. SIGNATURE OF WITNESS J. J. CONNOR		15. SIGNATURE OF WITNESS J. J. CONNOR		16. SIGNATURE OF WITNESS J. J. CONNOR	
17. SIGNATURE OF WITNESS J. J. CONNOR		18. SIGNATURE OF WITNESS J. J. CONNOR		19. SIGNATURE OF WITNESS J. J. CONNOR		20. SIGNATURE OF WITNESS J. J. CONNOR	
21. SIGNATURE OF WITNESS J. J. CONNOR		22. SIGNATURE OF WITNESS J. J. CONNOR		23. SIGNATURE OF WITNESS J. J. CONNOR		24. SIGNATURE OF WITNESS J. J. CONNOR	
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81. SIGNATURE OF WITNESS J. J. CONNOR		82. SIGNATURE OF WITNESS J. J. CONNOR		83. SIGNATURE OF WITNESS J. J. CONNOR		84. SIGNATURE OF WITNESS J. J. CONNOR	
85. SIGNATURE OF WITNESS J. J. CONNOR		86. SIGNATURE OF WITNESS J. J. CONNOR		87. SIGNATURE OF WITNESS J. J. CONNOR		88. SIGNATURE OF WITNESS J. J. CONNOR	
89. SIGNATURE OF WITNESS J. J. CONNOR		90. SIGNATURE OF WITNESS J. J. CONNOR		91. SIGNATURE OF WITNESS J. J. CONNOR		92. SIGNATURE OF WITNESS J. J. CONNOR	
93. SIGNATURE OF WITNESS J. J. CONNOR		94. SIGNATURE OF WITNESS J. J. CONNOR		95. SIGNATURE OF WITNESS J. J. CONNOR		96. SIGNATURE OF WITNESS J. J. CONNOR	
97. SIGNATURE OF WITNESS J. J. CONNOR		98. SIGNATURE OF WITNESS J. J. CONNOR		99. SIGNATURE OF WITNESS J. J. CONNOR		100. SIGNATURE OF WITNESS J. J. CONNOR	

CERTIFICATE OF DEATH

Reg. Dist. No.

9770

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Line Kiln 10X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Bell Last Bell		4. DATE OF DEATH Month Sept Day 3 Year 1958	
5. SEX Female	6. COLOR OR RACE n negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1905 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Bell		14. MOTHER'S MAIDEN NAME Mariah Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Hypostetic pneumonia DUE TO (b) Cerebrel Thrombosis DUE TO (c) Hypertensive Arteriosclerotic cardiovascular-renal disease CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcer			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 18, 1947 to Sept. 3, 1958 , that I last saw the deceased alive on September 3, 1958 and that death occurred at 3:45 pm from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel Mc Henry Mapp		DATE SIGNED Sept. 3, 1958	
PHYSICIAN'S NAME (Type) Lionel Mc Henry Mapp		ADDRESS (Street, city or town, state) Crownsville State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-6-58	22c. NAME OF CEMETERY OR CREMATORY FAIRVIEW	22d. LOCATION (City, town, or county) (State) Frederick Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks ADDRESS Frederick-Md		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		35		Male		White		1914		New York City	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
100 Broadway		Clerk		Heart Disease		Natural		1234		Yes	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED		NOTED	
Jan 1, 1879		New York City		High School		Married		J. J. Jones		J. J. Jones	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE	
John J. Jones		Mary J. Jones		Clerk		Homemaker		100 Broadway		100 Broadway	
FATHER'S DEATH		MOTHER'S DEATH		FATHER'S CAUSE		MOTHER'S CAUSE		FATHER'S MANNER		MOTHER'S MANNER	
1910		1912		Heart Disease		Heart Disease		Natural		Natural	
FATHER'S PLACE		MOTHER'S PLACE		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
New York City		New York City		High School		High School		1905		1905	
FATHER'S DEATH		MOTHER'S DEATH		FATHER'S CAUSE		MOTHER'S CAUSE		FATHER'S MANNER		MOTHER'S MANNER	
1910		1912		Heart Disease		Heart Disease		Natural		Natural	
FATHER'S PLACE		MOTHER'S PLACE		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
New York City		New York City		High School		High School		1905		1905	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 414 Cleveland Road				d. STREET ADDRESS 414 Cleveland Rd.			
3. NAME OF DECEASED (Type or print) First MIRIAM Middle FRANCE Last BELL				4. DATE OF DEATH Month Sept. Day 25 Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1905		9. AGE (In years last birthday) yrs. 53	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse Corp.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Yeatman				14. MOTHER'S MAIDEN NAME Ella May -- (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-05-9577		17. INFORMANT Mr. Edward H. Bell - 414 Cleveland Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.2 DUE TO Amnesia of lower Bowel Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Operated 7/25/58 Inoperable) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 17-240.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 9/25/58 , to 9/25/58 , 19 58 , that I last saw the deceased alive on 9/25/58 , 19 58 , and that death occurred at 3 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. L. Ball Jr.		M.D. 203 W Thapa Rd.		ADDRESS (Street, city or town, state)		DATE SIGNED 9/25/58	
PHYSICIAN'S NAME (Type) Linthicum							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/58	22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) Balto., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Vickers & Sons - Balto.				24a. REC'D BY REGISTRAR DATE SEP 29 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Duration of illness		8. Name of physician	
9. Name of informant		10. Signature of informant		11. Signature of physician		12. Signature of registrar	
13. Name of registrar		14. Signature of registrar		15. Signature of registrar		16. Signature of registrar	
17. Name of registrar		18. Signature of registrar		19. Signature of registrar		20. Signature of registrar	
21. Name of registrar		22. Signature of registrar		23. Signature of registrar		24. Signature of registrar	
25. Name of registrar		26. Signature of registrar		27. Signature of registrar		28. Signature of registrar	
29. Name of registrar		30. Signature of registrar		31. Signature of registrar		32. Signature of registrar	
33. Name of registrar		34. Signature of registrar		35. Signature of registrar		36. Signature of registrar	
37. Name of registrar		38. Signature of registrar		39. Signature of registrar		40. Signature of registrar	
41. Name of registrar		42. Signature of registrar		43. Signature of registrar		44. Signature of registrar	
45. Name of registrar		46. Signature of registrar		47. Signature of registrar		48. Signature of registrar	
49. Name of registrar		50. Signature of registrar		51. Signature of registrar		52. Signature of registrar	
53. Name of registrar		54. Signature of registrar		55. Signature of registrar		56. Signature of registrar	
57. Name of registrar		58. Signature of registrar		59. Signature of registrar		60. Signature of registrar	
61. Name of registrar		62. Signature of registrar		63. Signature of registrar		64. Signature of registrar	
65. Name of registrar		66. Signature of registrar		67. Signature of registrar		68. Signature of registrar	
69. Name of registrar		70. Signature of registrar		71. Signature of registrar		72. Signature of registrar	
73. Name of registrar		74. Signature of registrar		75. Signature of registrar		76. Signature of registrar	
77. Name of registrar		78. Signature of registrar		79. Signature of registrar		80. Signature of registrar	
81. Name of registrar		82. Signature of registrar		83. Signature of registrar		84. Signature of registrar	
85. Name of registrar		86. Signature of registrar		87. Signature of registrar		88. Signature of registrar	
89. Name of registrar		90. Signature of registrar		91. Signature of registrar		92. Signature of registrar	
93. Name of registrar		94. Signature of registrar		95. Signature of registrar		96. Signature of registrar	
97. Name of registrar		98. Signature of registrar		99. Signature of registrar		100. Signature of registrar	

MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09745

Reg. Dist. No.

9772

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u> c. LENGTH OF STAY IN lb <u>Few instants.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sun Ray's Drug Store</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4546 N. Rogers Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arnold Maccabbi Bick</u>		4. DATE OF DEATH Month Day Year <u>September 22rd. 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11/6/1900</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver for a Clothes Cleaner Org.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vienna, Austria, Europe.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Julius Bick</u>		14. MOTHER'S MAIDEN NAME <u>? ? Hein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>826-419040</u>	
17. INFORMANT <u>Dr. Dr. Max Herzberg, P.O. Hyatsville, M.D.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		DATE SIGNED <u>9/22/58</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 23/58.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shomre Mishmeres</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Johnson</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '58</u>	
ADDRESS <u>1124-26 W. North Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		YEAR	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
FINDINGS AT AUTOPSY		LABORATORY TESTS		TOXICOLOGY		HISTOPATHOLOGY		MICROSCOPIC FINDINGS	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY	
OFFICIAL SEAL		NOTARY SEAL		JURY SEAL		CORONER SEAL		STATE SEAL	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9773

CERTIFICATE OF DEATH

09746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4y 11m 9d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forrest Park d. STREET ADDRESS 3700 Block Edgerton Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Oliver Booth		4. DATE OF DEATH Month Day Year 9 29 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/11/89
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) handyman		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Booth		14. MOTHER'S MAIDEN NAME Elizabeth Giles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10 , 1953 to 9/29 , 1958 , that I last saw the deceased alive on 9/29 , 1958 , and that death occurred at 6:25 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Benedict, M. D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		DATE SIGNED Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-3-58		22b. DATE THEREOF 10-3-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope		22d. LOCATION (City, town, or county) (State) Sancti Spiritus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sowell		ADDRESS Prince Frederick, Md.	
24a. REC'D BY REGISTRAR OCT 6 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9774

CERTIFICATE OF DEATH

Reg. Dist. No.

09747

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1y 4m 20d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Morgan Middle Last Bowser				4. DATE OF DEATH Month 9 Day 15 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/10/64	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ellis Bowser				14. MOTHER'S MAIDEN NAME Amanda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-1089		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 023x IMMEDIATE CAUSE (a) Syphilitic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/19/57 , 19 58 , to 9/14/58 , that I last saw the deceased alive on 9/14/58 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon W. Whitt M.D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 9/15/58			
PHYSICIAN'S NAME (Type) Leon W. Whitt, M. D.				ADDRESS Crownsville State Hospital, Md. DATE 9/15/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/58		22c. NAME OF CEMETERY OR CREMATORY Mount Calvary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Chroy O Wilson				24a. REC'D BY REGISTRAR DATE SEP 16 1958			
				24b. REGISTRAR'S SIGNATURE Arthur J. Hanes			

2522

225

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09748

9775

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>10y 9m 25d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>631 Archer Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Bracey</u> Last <u>Bracey</u>				4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1876</u>		9. AGE (In years, months, and days) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Needam Bracey</u>				14. MOTHER'S MAIDEN NAME <u>Martha</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Scarring</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/05</u> , 19 <u>47</u> , to <u>9/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/30</u> , 19 <u>58</u> , and that death occurred at <u>-----</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>9/30/58</u> ACTUAL SIGNATURE <u>L. Benedict</u> M.D. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u> <u>Crownsville State Hospital, Md.</u> <u>9/30/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Cooper</u>				24a. REC'D BY REGISTRAR <u>aw</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Cooper</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09749

9776

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Severna Park Md.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>ALB.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Nora</i> First <i>Brauford</i> Middle <i>Severna</i> Last		4. DATE OF DEATH Month <i>Sept.</i> Day <i>27</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 30th 1895</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Caleb Briggs</i>		14. MOTHER'S MAIDEN NAME <i>Eleanor Briggs ALB Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Elizabeth Queen</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/25/58</i> 19, to <i>9/27/58</i> 19, that I last saw the deceased alive on <i>9/25/58</i> 19, and that death occurred at <i>12:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John F. Alexander M.D.</i>		ADDRESS (Street, city or town, state) <i>Glen Burnie Md.</i> DATE SIGNED <i>9/29/58</i>	
PHYSICIAN'S NAME (Type) <i>JOHN G. ALEXANDER M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/1/1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Rest Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>HARMON'S Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Katie R. Williams</i>		ADDRESS <i>322 N. Broadway St.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>OCT 1 '58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09750

9777

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 220 6th Ave NE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary R. Bromley		4. DATE OF DEATH Month Day Year Sept. 18 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1886
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME James Lowe		16. MOTHER'S MAIDEN NAME ? ? ?	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. none	
19. INFORMANT Mrs R. P. Ward, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 52 , to 9/18/58 , 19 58 , that I last saw the deceased alive on 9/17/58 , 19 58 , and that death occurred at 11 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gustav H. Paulsen		ADDRESS (Street, city or town, state) DATE SIGNED 5 First Ave SE, Glen Burnie, Md.	
PHYSICIAN'S NAME (Type) G. H. Faubert, M.D.,		5 First Ave SE, Glen Burnie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/20/58	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE SEP 22 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hays

9778

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. LENGTH OF STAY IN 1b three days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL		d. STREET ADDRESS Aguasco	
3. NAME OF DECEASED (Type or print) First DAVID Middle BROOKS Last BROOKS		4. DATE OF DEATH Month 9 Day 12 Year 1958	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 5, 1891
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerry Brooks		14. MOTHER'S MAIDEN NAME Mary Brooks (married name)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. —	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure (acute) 422.1 DUE TO Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Hour a. m. — p. m. — Month — Day — Year 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 9/12 , 19 58 to 9/12 , 19 58 , that I last saw the deceased alive on 9/12 , 19 58 , and that death occurred at 10:15 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Benedict M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Crownville State Hospital Crownville, Md.	
PHYSICIAN'S NAME (Type) E. BENEDICT M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) buried	22b. DATE THEREOF 9/17/58	22c. NAME OF CEMETERY OR CREMATORY St. Phillips	22d. LOCATION (City, town, or county) (State) Aguasco Md.
23. FUNERAL DIRECTOR'S SIGNATURE James S. Nelson		ADDRESS Aguasco Md.	
24a. RECEIVED BY REGISTRAR SEP 15 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

28 2/12 28

George W. Hale
 General, 2nd

2/12

28

George W. Hale

General, 2nd

CERTIFICATE OF DEATH

09752

Reg. Dist. No.

9747

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hosp.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH WILLIAM BROSH				4. DATE OF DEATH Month Day Year September 15, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1904	
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James J. Brosh, Sr.				14. MOTHER'S MAIDEN NAME Mary Skoda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) Unknown			
17. INFORMANT Mrs. Amelia M. Brosh				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - terminal Carcinoma 157X DUE TO Metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Pancreas with DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/14, 1958 to 9/15, 1958 , that I last saw the deceased alive on 9/14, 1958 , and that death occurred at 2:44 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 201 Balto-Annapolis Bldg, Glen Burnie Md. DATE SIGNED SEP 18 '58							
ACTUAL SIGNATURE J. Fred Hawkins, Jr.				M.D. Glen Burnie, Md.			
PHYSICIAN'S NAME (Type) J. Fred HAWKINS, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 19 1958		22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard P. Singlet				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09753

9748

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RICHARD Middle B. Last BROWN				4. DATE OF DEATH Month September Day 25 Year 1958			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-13-58	
9. AGE (In years last birthday) yrs. 11		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stanley B. Brown		14. MOTHER'S MAIDEN NAME Ann Palmer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. —		17. INFORMANT Ann Palmer 1943 West St. Annapolis, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis. DUE TO 763.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Neural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul F. Guerin		EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/25/58	
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10-1-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill Cem.		22d. LOCATION (City, town, or county) Annapolis, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE William Reese Jr. - Anna, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE OCT 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

2039152XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

615-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09754

9779

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Herald Harbor, Crownsville Md.</i>		c. LENGTH OF STAY IN 1b <i>25 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Herald Harbor, Crownsville Md.</i>		d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ettie</i> Middle <i>L.</i> Last <i>Burdette</i>				4. DATE OF DEATH Month <i>Sept</i> Day <i>21</i> Year <i>1958</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 3, 1858</i>		9. AGE (In years last birthday) <i>100 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <i>ALMANZA LAYTON</i>				14. MOTHER'S MAIDEN NAME <i>JULIA W. LACEY</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>John L. Walsh</i>				Address <i>Herald Harbor, Crownsville Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Oct 4</i> to <i>Sept 21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 20</i> , 19 <i>58</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Edward G. Merritt</i>				ADDRESS (Street, city or town, state) <i>Gambrill, Md.</i>				DATE SIGNED <i>9-22-58</i>	
PHYSICIAN'S NAME (Type) <i>Edward Merritt</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/25/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cemetery</i>		22d. LOCATION (City, town, or county) <i>Boyd Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thompson</i>	

CERTIFICATE OF DEATH

2739

REG. NO.

DATE OF DEATH

SEX

PLACE OF BIRTH

AGE

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF DEPUTY REGISTRAR

NAME OF DEPUTY CLERK

NAME OF DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY DEPUTY REGISTRAR

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NAME OF DEPUTY DEPUTY DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9780

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Odenton

c. LENGTH OF STAY IN 1b

Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Odenton

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

#1 Gill st.

d. STREET ADDRESS

#1 Gill St.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Joseph

Middle

E.

Last

Burton

4. DATE
OF
DEATH

Month

Day

Year

September 9, 19 58

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

March 9, 1956

9. AGE (in years
last birthday)

2 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

//////////

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Calvin A. Burton

14. MOTHER'S MAIDEN NAME

Mildred E. Goolsby

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

Mr. Calvin A. Burton,

Same As #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)Asphyxiation due to ~~swallow~~ regurgitation ofINTERVAL BETWEEN
ONSET AND DEATH

756.2 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) food as deceased had a congenital paralysis of

DUE TO

(c) oesophagus.

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☒
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

As above stated in #18

20c. TIME OF INJURY

Hour a. m.

3.20 p. m.

Month, Day, Year

9/9/58

19

20d. INJURY OCCURRED

While at work ☐Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Odenton

(County)

A.A.

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Gustave H. Faubert, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9/9/58

EXAMINER'S
NAME (Type)

Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Sept. 12/58

22c. NAME OF CEMETERY OR CREMATORY

Glen Haven Cem.

22d. LOCATION (City, town, or county)

Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

R. V. Singleton

ADDRESS

Glen Burnie, Md.

24a. REC'D BY REGISTRAR

DATE SEP 16 '58

24b. REGISTRAR'S SIGNATURE

Charles J. Hanna

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH

11

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of birth
7. Usual residence
8. Cause of death
9. Manner of death
10. Signature of medical examiner
11. Signature of coroner
12. Signature of registrar

CERTIFICATE OF DEATH

Reg. Dist. No.

9749

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Elliott Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elise Mohler Buser</i>		4. DATE OF DEATH <i>9-27-58</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15-1881</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13. BIRTHPLACE (State or foreign country) <i>Switzerland</i>		14. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. FATHER'S NAME <i>Wilhelm Mohler</i>		16. MOTHER'S MAIDEN NAME <i>Rosine Greider</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		18. SOCIAL SECURITY NO. <i>-</i>	
19. INFORMANT <i>Wm Buser</i>		Address <i>Annapolis R 70 Md.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous primary site</i> <i>1992</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2?</i> DUE TO (c) <i>18 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>9-26-58</i> to <i>9-27-58</i> , that I last saw the deceased alive on <i>9-26-58</i> , and that death occurred at <i>1 P</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED <i>9-27-58</i>
ACTUAL SIGNATURE <i>Frank M Shipley</i> M.D.		ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-29-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cent</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR <i>SEP 29 '58</i>	
ADDRESS <i>Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE <i>James S. Thoma</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

89758

File No.

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>	
<p>4. Place of birth: <u>New York City</u></p>	
<p>5. Date of death: <u>Dec 15, 1950</u></p>	
<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>	
<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>Dr. J. Smith</u></p>	
<p>10. Signature of registrar: <u>John Doe</u></p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9781

CERTIFICATE OF DEATH

Reg. Dist. No.

09757

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>4 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manor Nursing Home</i>		d. STREET ADDRESS <i>1915 McCulloh St.</i>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>—</i> Last <i>Carter</i>		4. DATE OF DEATH Month <i>9</i> — Day <i>14</i> Year <i>1958</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-10-1897</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Garage Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>—</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Pardyring</i>		14. MOTHER'S MAIDEN NAME <i>Mizie Winsley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>220-09-94N</i>	
17. INFORMANT <i>Gertrude Stewart</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X cerebral Hemorrhage</i> DUE TO <i>hypertensive Cardio V. Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized arteriosclerosis</i> DUE TO <i>—</i> (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Urinary Infection - Chlamydia Cystitis Pylitis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/22</i> , 19 <i>55</i> , to <i>9/14</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/13</i> , 19 <i>58</i> , and that death occurred at <i>9:45</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Johns Keenleys</i> M.D.		ADDRESS (Street, city or town, state) <i>10911 St Odenton</i>	
PHYSICIAN'S NAME (Type) <i>Johns Keenleys</i>		DATE SIGNED <i>9/14/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-20-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Calvary Bur & C. Co</i>		22d. LOCATION (City, town, or county) (State) <i>Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rayner Sanders</i>		ADDRESS <i>217 E Preston St</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinner</i>	
DATE <i>SEP 29 1958</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9782

CERTIFICATE OF DEATH

Reg. Dist. No.

09758

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1007 Providence St.		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Anty Last Cornish				4. DATE OF DEATH Month September Day 3 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1888 Sept. 18, 1958-	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME William H. Cornish				14. MOTHER'S MAIDEN NAME Elisabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c) Prostate Hypertrophy							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 15, 19 58 , to Sept. 3 58 , that I last saw the deceased alive on September 2, 19 58 , and that death occurred at 12:04 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Lionel Mc Kenry Mapp				M.D. Crownsville State Hospital			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept. 8-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis A. Henry				ADDRESS 578 W Biddle		24a. REC'D BY REGISTRAR DATE SEP 5 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Sex [Illegible]	
Date of Birth [Illegible]		Place of Birth [Illegible]	
Date of Death [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]	
Physician's Name [Illegible]		Hospital or Institution [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Signature [Illegible]		Place of Signature [Illegible]	

DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 [Illegible text on the right margin]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09759

9783

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Heights</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 Clifton Ave</u>		d. STREET ADDRESS <u>12 Clifton Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Meta</u> Middle <u>Geyer</u> Last <u>cowenhoven</u>		4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Martinsburg W. Va. U.S.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James F Geyer</u>		14. MOTHER'S MAIDEN NAME <u>Stolper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Daughter Mrs Va Teano (same)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis C. V. disease</u> DUE TO <u>Gen Arteriosclerosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-24-58</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. HAHN</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>9-24-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Severna Park MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. K. Brown</u>		ADDRESS <u>Martinsburg, W. Va.</u>	
24a. REC'D BY REGISTRAR <u>SEP 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

CERTIFICATE OF DEATH

DECEASED
TWIN
BORN

1. Name of deceased: *TWIN*

2. Sex: *Male*

3. Age: *25*

4. Date of birth: *1910*

5. Date of death: *1935*

6. Place of death: *Home*

7. Cause of death: *Heart disease*

8. Signature of physician: *[Signature]*

9. Signature of registrar: *[Signature]*

10. Date of registration: *1935*

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9750

CERTIFICATE OF DEATH

09760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,		c. LENGTH OF STAY IN 1b 61 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Anna. Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Ella Last CRANFORD		4. DATE OF DEATH Month SEP Day 13 Year 19 58	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Feb 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM EDWARD LAMB		14. MOTHER'S MAIDEN NAME CARRIE REGINA BURK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT U.S. Naval Hospital, Annapolis, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 170X (b) Carcinoma, rt. breast DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right pleural effusion			
INTERVAL BETWEEN ONSET AND DEATH More than 6 mo 4 Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-29 , 1958 , to 9-12 , 1958 , that I last saw the deceased alive on 9-12 , 1958 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert C. Lanning		M.D. U.S. Naval Hosp., Annapolis, Md. 9-13-58	
PHYSICIAN'S NAME (Type) LCDR Robert C. LANNING MC USA			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 16, 58	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemeteery	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR SEP 17 58		24b. REGISTRAR'S SIGNATURE Charles S. Hunt	

CERTIFICATE OF DEATH

MAXYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

PLACE OF DEATH HOME		SEX MALE	
DATE OF DEATH JAN 10 1918		AGE 25	
NAME OF DECEASED JOHN J. JONES		OCCUPATION LABORER	
PLACE OF BIRTH NEW YORK		COLOR WHITE	
MARITAL STATUS SINGLE		EDUCATION HIGH SCHOOL	
CAUSE OF DEATH TUBERCULOSIS		PERIOD OF ILLNESS 6 MONTHS	
PLACE OF INTERMENT MOUNT RAINIER CEMETERY		NAME OF FUNERAL HOME JONES & SONS	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF DECEASED'S NEXT OF KIN (None)		SIGNATURE OF DECEASED'S PHYSICIAN (None)	
SIGNATURE OF DECEASED'S MINISTER (None)		SIGNATURE OF DECEASED'S MARRIAGE OFFICER (None)	
SIGNATURE OF DECEASED'S BAPTIST MINISTER (None)		SIGNATURE OF DECEASED'S METHODIST MINISTER (None)	
SIGNATURE OF DECEASED'S PRESBYTERIAN MINISTER (None)		SIGNATURE OF DECEASED'S LUTHERAN MINISTER (None)	
SIGNATURE OF DECEASED'S EPISCOPALIAN MINISTER (None)		SIGNATURE OF DECEASED'S ROMAN CATHOLIC MINISTER (None)	
SIGNATURE OF DECEASED'S OTHER MINISTER (None)		SIGNATURE OF DECEASED'S OTHER MINISTER (None)	

MEDICAL CERTIFICATION

VS. A15ME(5)
SM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9785
CERTIFICATE OF DEATH

09782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY St. Mary's MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 1y 4m 4d	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlotte Hall 18X-2	
3. NAME OF DECEASED (Type or print) First Mamie Middle Last Dade		4. DATE OF DEATH Month 9 Day 21 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898
9. AGE (In years, months, and days) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 422.1 DUE TO ACVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Unknown		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/17 , 19 57 , to 9/21 , 19 58 , that I last saw the deceased alive on 9/21/58 , 19 58 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Benedict, M. D.		DATE SIGNED 9/22/58	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/58	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR SEP 29 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	
13. Name of Informant		14. Relationship to Deceased		15. Signature of Informant	
16. Name of Attending Physician		17. Signature of Attending Physician		18. Date of Signature	
19. Name of Medical Examiner		20. Signature of Medical Examiner		21. Date of Signature	
22. Name of Coroner		23. Signature of Coroner		24. Date of Signature	
25. Name of Burial Place		26. Signature of Burial Place		27. Date of Signature	
28. Name of Funeral Home		29. Signature of Funeral Home		30. Date of Signature	
31. Name of Cemetery		32. Signature of Cemetery		33. Date of Signature	
34. Name of Interment Place		35. Signature of Interment Place		36. Date of Signature	
37. Name of Burial Place		38. Signature of Burial Place		39. Date of Signature	
40. Name of Interment Place		41. Signature of Interment Place		42. Date of Signature	
43. Name of Burial Place		44. Signature of Burial Place		45. Date of Signature	
46. Name of Interment Place		47. Signature of Interment Place		48. Date of Signature	
49. Name of Burial Place		50. Signature of Burial Place		51. Date of Signature	
52. Name of Interment Place		53. Signature of Interment Place		54. Date of Signature	
55. Name of Burial Place		56. Signature of Burial Place		57. Date of Signature	
58. Name of Interment Place		59. Signature of Interment Place		60. Date of Signature	
61. Name of Burial Place		62. Signature of Burial Place		63. Date of Signature	
64. Name of Interment Place		65. Signature of Interment Place		66. Date of Signature	
67. Name of Burial Place		68. Signature of Burial Place		69. Date of Signature	
70. Name of Interment Place		71. Signature of Interment Place		72. Date of Signature	
73. Name of Burial Place		74. Signature of Burial Place		75. Date of Signature	
76. Name of Interment Place		77. Signature of Interment Place		78. Date of Signature	
79. Name of Burial Place		80. Signature of Burial Place		81. Date of Signature	
82. Name of Interment Place		83. Signature of Interment Place		84. Date of Signature	
85. Name of Burial Place		86. Signature of Burial Place		87. Date of Signature	
88. Name of Interment Place		89. Signature of Interment Place		90. Date of Signature	
91. Name of Burial Place		92. Signature of Burial Place		93. Date of Signature	
94. Name of Interment Place		95. Signature of Interment Place		96. Date of Signature	
97. Name of Burial Place		98. Signature of Burial Place		99. Date of Signature	
100. Name of Interment Place		101. Signature of Interment Place		102. Date of Signature	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9751

CERTIFICATE OF DEATH

09763

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.		c. LENGTH OF STAY IN 1b 12 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S.N.H. Annapolis, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ersal Middle Dayton Last DAVEY		4. DATE OF DEATH Month Sep. Day 8 Year 19 58	
5. SEX M	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-93
9. AGE (In years last birthday) yrs. 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John DAVEY		14. MOTHER'S MAIDEN NAME Bertha SCHAEFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-30-4886	
17. INFORMANT U.S. Naval Hospital, Annapolis, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANOXIA 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Status Asthmaticus DUE TO (c) Bronchial Asthma INTERVAL BETWEEN ONSET AND DEATH 5 hours 5 Days Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Sep , 19 58 , to 8 Sep , 19 58 , that I last saw the deceased alive on 8 Sep , 19 58 , and that death occurred at 4:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S.N.Hosp. Annapolis, Md. DATE SIGNED 9-8-58 ACTUAL SIGNATURE E. L. Gould M.D. PHYSICIAN'S NAME (Type) E. L. GOULD LT MC USNR			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
ADDRESS Annapolis, Maryland		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

CERTIFICATE OF DEATH

Reg. No. 14

NAME OF DECEASED JAMES H. HARRIS		DATE OF BIRTH 1890-12-15		PLACE OF BIRTH BALTIMORE, MARYLAND	
MARRIED MRS. JAMES H. HARRIS		DATE OF MARRIAGE 1915-08-15		PLACE OF MARRIAGE BALTIMORE, MARYLAND	
OCCUPATION LABORER		DATE OF DEATH 1935-08-15		PLACE OF DEATH BALTIMORE, MARYLAND	
CAUSE OF DEATH HEART DISEASE		DATE OF INTERMENT 1935-08-18		PLACE OF INTERMENT BALTIMORE, MARYLAND	
MANNER OF DEATH NATURAL		DATE OF BURIAL 1935-08-18		PLACE OF BURIAL BALTIMORE, MARYLAND	
EDUCATION HIGH SCHOOL		DATE OF CREMATION 1935-08-18		PLACE OF CREMATION BALTIMORE, MARYLAND	
RELIGION METHODIST		DATE OF EXHUMATION 1935-08-18		PLACE OF EXHUMATION BALTIMORE, MARYLAND	
SPECIAL INSTRUCTIONS None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF DECEASED None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF NEXT OF KIN None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF CORONER None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF JURY None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF JUDGE None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF CLERK None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF DECEASED None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF NEXT OF KIN None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF CORONER None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF JURY None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF JUDGE None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	
SIGNATURE OF CLERK None		DATE OF REINTERMENT 1935-08-18		PLACE OF REINTERMENT BALTIMORE, MARYLAND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6233 9/19/58 gsj

9786

CERTIFICATE OF DEATH

09764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa Co Md</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marley Park</u>			d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Horsey</u> Last <u></u>			4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>19 58</u>		
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1885</u>	9. AGE (In years last birthday) <u>73 1/2</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salmon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Longshore</u>		11. BIRTHPLACE (State or foreign country) <u>aa Co Md</u>	
13. FATHER'S NAME <u>Howard Horsey</u>			14. MOTHER'S MAIDEN NAME <u>Louise Grunow</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT (Address) <u>Laura Horsey Marley Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the rectum</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>February 10, 19 58</u> , to <u>Sept 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 8</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>R. M. McHughlin</u>			DATE SIGNED <u>Sept 9 1958</u>		
PHYSICIAN'S NAME (Type) <u></u>			ADDRESS (Street, city or town, state) <u>Pasadena Maryland</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Marley Neck</u>		22d. LOCATION (City, town, or county) (State) <u>aa Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac L Brown</u>		ADDRESS <u>108 W Montgomery St</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kane</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9752

CERTIFICATE OF DEATH

09765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>18 HR.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAYO</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSPITAL</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>L.</u> Last <u>DOWNS</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 AUGUST '58</u>		9. AGE (In years last birthday) yrs. <u>25</u>	IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u>25</u> Min. <u>25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND B.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William DOWNS</u>				14. MOTHER'S MAIDEN NAME <u>BEATRICE THOMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEHYDRATION</u> <u>764.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIARRHEA, NON-SPECIFIC</u> DUE TO (c) <u>3 DAYS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MALNUTRITION</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 SEPT., 1958</u> , to <u>8 SEPT., 1958</u> , that I last saw the deceased alive on <u>7 SEPT., 1958</u> , and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James I. Hudson, Jr.</u>				M.D. <u>RIVER CLUB ESTATES EDGEWATER, MD.</u> DATE SIGNED <u>9 SEPT 58</u>			
PHYSICIAN'S NAME (Type) <u>JAMES I. HUDSON, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		22d. LOCATION (City, town, or county) (State) <u>Edgewater, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beese & Anna, Inc.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

2039152XV4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9787

CERTIFICATE OF DEATH

Reg. Dist. No.

09766

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RIVIERA BEACH</u>	c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>	x. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RIVIERA BEACH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FORT SMALLWOOD ROAD</u>		d. STREET ADDRESS <u>1 FORT SMALLWOOD ROAD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>EDELMANN</u> Last <u>EDELMANN</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>	IF UNDER 24 HRS. Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRON MOULDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IRON FOUNDRY</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>JOHN EDELMANN</u>	
14. MOTHER'S MAIDEN NAME <u>MARGIE MILLER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>218-01-6034</u>		17. INFORMANT <u>MRS. ANNIE THOMAS</u> Address <u>FORT SMALLWOOD ROAD PASADENA, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC CARDIO VASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT 19, 1958</u> , to <u>SEPT 27, 1958</u> , that I last saw the deceased alive on <u>SEPT 26, 1958</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D. <u>RIVIERA BEACH</u>		DATE SIGNED <u>9/27/58</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		<u>PASADENA, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McCully Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Brownsville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>		ADDRESS <u>130 E. Fort Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

1950

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9753

Reg. Dist. No. 19767

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md</u>		c. LENGTH OF STAY IN 1b <u>x Best Gate, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Arundel General Hospital</u>		d. STREET ADDRESS <u>111 Maybelle Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>A. Edwards</u> Last <u></u>		4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1923</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterburg Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Waterburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Richard Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mary Edwards</u>		Address <u>Best Gate 111 Maybelle Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>835x</u> DUE TO <u>Multiple Injuries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> (b) <u></u> (c) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cough between Hopper & truck body</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>9.9.58</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AAco</u>		20f. (City or town) (County) (State) <u>Best Gate, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Luhaardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Luhaardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9.10.58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u>		22d. LOCATION (City, town, or county) (State) <u>Best Gate, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, Jr.</u>		ADDRESS <u>Anna, Md.</u>	
24a. REC'D BY REGISTRAR <u>9/17/58</u>		24b. REGISTRAR'S SIGNATURE <u>William Geese, Jr.</u>	

FOR STATE
HEALTH DEPT

(2)

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT, AND A COPY OF IT IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT.

DEATH CERTIFICATE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STANDARD STATE OF ILLINOIS - EXHIBIT 18

9/1/52 William K. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x IGLEHART</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HILL GENERAL Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Howard</u> Middle <u>Exum</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-29-1947</u>	9. AGE (In years last birthday) <u>10</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
13. FATHER'S NAME <u>HARVEY W. EXUM</u>				14. MOTHER'S MAIDEN NAME <u>MILDRED HEARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>HARVEY W. EXUM</u> Address <u># 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple injuries</u> DUE TO <u>813x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto - R178 - riding bicycle</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9-11</u> p. m. <u>1958</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>			
20f. (City or town) <u>IGLEHART</u>		20g. (County) <u>ANNE ARUNDEL</u>		20h. (State) <u>MD.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-11-58</u>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>			
22d. LOCATION (City, town, or county) <u>ANNAPOLIS</u>		22e. (State) <u>MD.</u>		22f. (Country) <u>—</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. (State) <u>MD.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be used within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar plus a burial permit. File pages 3 and 4 with the registrar plus a burial permit.

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

09769

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN PARK		c. LENGTH OF STAY IN 1b 50	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 W 12th Ave.		d. STREET ADDRESS 1208 W 12th AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LULA GRACE FEUERSTEIN		4. DATE OF DEATH SEPT. 7 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 12, 1874
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR: Months 7 Days 7 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL TAYLOR		14. MOTHER'S MAIDEN NAME SARAH E. LABARRE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. FRANK FORSYTHE		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration - Acidosis - Cerebral - Shock 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage DUE TO (c) Perforation - Gall Bladder + Unabsorbed A.S.C.H.D.			
INTERVAL BETWEEN ONSET AND DEATH 6-Sept-58- 7-Sept-58			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 Aug , 19 58 , to 6 Sept , 19 58 , that I last saw the deceased alive on 6 Sept 58 , 19 58 , and that death occurred at 9 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4016 Ritchie Hwy DATE SIGNED 9 Sept 58			
ACTUAL SIGNATURE Andrew R. Sosnowski		M.D. 4016 Ritchie Hwy	
PHYSICIAN'S NAME (Type) Andrew R. Sosnowski			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept 10 1958	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM		22d. LOCATION (City, town, or county) (State) PITCHY Hgwy, AA Co, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Jones		ADDRESS 4001 Ritchie Hwy	
24a. REC'D BY REGISTRAR SEP 11 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. PLACE OF DEATH <i>Home</i>	
9. CAUSE OF DEATH <i>Heart Disease</i>		10. MEDICAL HISTORY <i>None</i>	
11. DATE OF DEATH <i>Jan 20 1945</i>		12. TIME OF DEATH <i>10:00 AM</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF PHYSICIAN <i>John Doe</i>		16. SIGNATURE OF CORONER <i>John Doe</i>	
17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>	
21. SIGNATURE OF JURY <i>John Doe</i>		22. SIGNATURE OF JURY <i>John Doe</i>	
23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>	
27. SIGNATURE OF JURY <i>John Doe</i>		28. SIGNATURE OF JURY <i>John Doe</i>	
29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>	
33. SIGNATURE OF JURY <i>John Doe</i>		34. SIGNATURE OF JURY <i>John Doe</i>	
35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>	
39. SIGNATURE OF JURY <i>John Doe</i>		40. SIGNATURE OF JURY <i>John Doe</i>	
41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>	
45. SIGNATURE OF JURY <i>John Doe</i>		46. SIGNATURE OF JURY <i>John Doe</i>	
47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>	
51. SIGNATURE OF JURY <i>John Doe</i>		52. SIGNATURE OF JURY <i>John Doe</i>	
53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>	
57. SIGNATURE OF JURY <i>John Doe</i>		58. SIGNATURE OF JURY <i>John Doe</i>	
59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>	
63. SIGNATURE OF JURY <i>John Doe</i>		64. SIGNATURE OF JURY <i>John Doe</i>	
65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>	
69. SIGNATURE OF JURY <i>John Doe</i>		70. SIGNATURE OF JURY <i>John Doe</i>	
71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>	
75. SIGNATURE OF JURY <i>John Doe</i>		76. SIGNATURE OF JURY <i>John Doe</i>	
77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>	
81. SIGNATURE OF JURY <i>John Doe</i>		82. SIGNATURE OF JURY <i>John Doe</i>	
83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>	
87. SIGNATURE OF JURY <i>John Doe</i>		88. SIGNATURE OF JURY <i>John Doe</i>	
89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>	
93. SIGNATURE OF JURY <i>John Doe</i>		94. SIGNATURE OF JURY <i>John Doe</i>	
95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>	
99. SIGNATURE OF JURY <i>John Doe</i>		100. SIGNATURE OF JURY <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9789

CERTIFICATE OF DEATH

Reg. Dist. No.

09770

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived.) If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Best Gate</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Best Gate</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Box 410</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alvina</u> Middle <u>Balloway</u> Last <u>Balloway</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Edgewater, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benny Brown</u>	
14. MOTHER'S MAIDEN NAME <u>Mary L. Vauls</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Elyah Balloway - Best Gate, Md.</u> Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> DUE TO <u>bag liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mon</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/12</u> , 19 <u>58</u> , to <u>9/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>58</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.		DATE SIGNED <u>31 October 1958</u>	
PHYSICIAN'S NAME (Type) <u>Dr. THEODORE H. JOHNSON</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9-21-58</u>	<u>Nopes Chapel</u>	<u>Edgewater, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 1958</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Haines</u>	

3790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>				c. LENGTH OF STAY IN 1b _____			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Children's Center</u>				d. STREET ADDRESS <u>1636 No. St., N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Peter Gayles</u>				4. DATE OF DEATH Month Day Year <u>Sept. 22 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26 1957</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Jupiter Gayles</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Lorraine Gayles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. _____			
17. INFORMANT <u>Mother Lillian Lorraine Gayles</u>				Address <u>1636 No. St., N.W., Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> 752x DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>meningitis</u> (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2/23</u> , 19 <u>58</u> , to <u>9/22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/22</u> , 19 <u>58</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md</u> DATE SIGNED <u>9/23/58</u>							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmentraut M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmentraut M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 24, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>District Training School</u>		22d. LOCATION (City, town, or county) <u>Laurel, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Moore Jr.</u> ADDRESS <u>District Training School Laurel, Maryland</u>							
24a. REC'D BY REGISTRAR DATE <u>SEP 26 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

0100

WILLIAM BONNIE
JAN 1 1900
MAY 1 1900
JUN 1 1900
JUL 1 1900
AUG 1 1900
SEP 1 1900
OCT 1 1900
NOV 1 1900
DEC 1 1900

Name of Deceased		Date of Death	
Sex		Age	
Place of Birth		Usual Residence	
Cause of Death		Manner of Death	
Physician's Signature		Medical Examiner's Signature	
Date of Report		Place of Report	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9791 CERTIFICATE OF DEATH

Reg. Dist. No.

09772

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN lb 9y 2m 25d			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 3 Vol-4			
3. NAME OF DECEASED (Type or print) First George Middle Giles Last Giles				4. DATE OF DEATH Month 9 Day 26 Year 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1904	
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months 54 Days 26 Hours 58 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 026X IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Chronic Brain Syndrome with CNS Lues Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome with CNS Lues DUE TO (c) Chronic Brain Syndrome with CNS Lues				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9 Fracture of left hip				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 7/1 , 19 49 , to 9/26 , 19 58 , that I last saw the deceased alive on 9/26 , 19 58 , and that death occurred at 12:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 9/26/58 ACTUAL SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital, Md. 9/26/58 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 9/26/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-29-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William G. Reese, Jr. Anna, Md.				24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE Charles E. Jones	

9792

CERTIFICATE OF DEATH

Reg. Dist. No. 89773

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>301-4</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BAR HARBOR</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Baltimore, MD</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Herbert</i> Last <i>Graulung</i>				4. DATE OF DEATH Month <i>9</i> Day <i>15</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 13, 1894</i>		9. AGE (In years last birthday) <i>64</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>mech. Eng.</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John W. Graulung</i>				14. MOTHER'S MAIDEN NAME <i>Augusta Fischer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>112-07-9876</i>		17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of bowels</i> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>about 1 year</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive cardiac vascular disease (2)</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/29</i> , 19 <i>48</i> , to <i>9/15</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/14</i> , 19 <i>58</i> , and that death occurred at <i>10 A.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Harry Deibel</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>1226 Hanover St Baltimore 30 2nd</i>			
PHYSICIAN'S NAME (Type) <i>DR. HARRY DEIBEL</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-17-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>London Pk. Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes</i>				ADDRESS <i>1302 Fort me</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 18 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. K...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ANNAPOLIS STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 5, 6, 7, 12 Film G234 10-14-58 et
9794
CERTIFICATE OF DEATH

09775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>20</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West River md</i>		c. LENGTH OF STAY IN 1b <i>1 yr 8 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>West River</i>	
3. NAME OF DECEASED (Type or print) <i>Nathaniel L. Guy</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>12</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 26</i>
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Educator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Colanthe India</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Francesco Guy</i>		14. MOTHER'S MAIDEN NAME <i>Sharma</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Barrington Guy Sharma</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial failure</i> <i>592X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary arteriosclerosis</i> DUE TO (c) <i>chronic nephritis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 8</i> , 19 <i>58</i> , to <i>Sept 12</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 9</i> , 19 <i>58</i> , and that death occurred at <i>11:50 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Lithuan, md</i> DATE SIGNED <i>9-15-58</i> ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D. <i>Lithuan, md</i> PHYSICIAN'S NAME (Type) <i>Emily H. Wilson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Entombment</i>		22b. DATE THEREOF <i>Sept 15/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Bladensburg md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i>		24a. REC'D BY REGISTRAR <i>SEP 16 '58</i>	
ADDRESS <i>Salisbury</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

CERTIFICATE OF DEATH

0784

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. RACE</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. SOCIAL CLASS</p> <p>12. DATE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. PLACE OF DEATH</p> <p>15. CAUSE OF DEATH</p> <p>16. MANNER OF DEATH</p> <p>17. SIGNATURE OF REGISTRAR</p> <p>18. SIGNATURE OF WITNESSES</p> <p>19. SIGNATURE OF DECEASED</p> <p>20. SIGNATURE OF NEXT OF KIN</p> <p>21. SIGNATURE OF MEDICAL OFFICER</p> <p>22. SIGNATURE OF CHURCH OFFICER</p> <p>23. SIGNATURE OF BURIAL OFFICER</p> <p>24. SIGNATURE OF FUNERAL DIRECTOR</p> <p>25. SIGNATURE OF CEMETERY OFFICER</p> <p>26. SIGNATURE OF HEALTH OFFICER</p> <p>27. SIGNATURE OF VITALS OFFICER</p> <p>28. SIGNATURE OF RECORDS OFFICER</p> <p>29. SIGNATURE OF ARCHIVE OFFICER</p> <p>30. SIGNATURE OF LIBRARY OFFICER</p> <p>31. SIGNATURE OF MUSEUM OFFICER</p> <p>32. SIGNATURE OF BOTANICAL GARDEN OFFICER</p> <p>33. SIGNATURE OF ZOOLOGICAL GARDEN OFFICER</p> <p>34. SIGNATURE OF ASTRONOMICAL OBSERVATORY OFFICER</p> <p>35. SIGNATURE OF METEOROLOGICAL OFFICER</p> <p>36. SIGNATURE OF MARINE OFFICER</p> <p>37. SIGNATURE OF AIR FORCE OFFICER</p> <p>38. SIGNATURE OF NAVY OFFICER</p> <p>39. SIGNATURE OF ARMY OFFICER</p> <p>40. SIGNATURE OF AIR FORCE OFFICER</p> <p>41. SIGNATURE OF NAVY OFFICER</p> <p>42. SIGNATURE OF ARMY OFFICER</p> <p>43. SIGNATURE OF AIR FORCE OFFICER</p> <p>44. SIGNATURE OF NAVY OFFICER</p> <p>45. SIGNATURE OF ARMY OFFICER</p> <p>46. SIGNATURE OF AIR FORCE OFFICER</p> <p>47. SIGNATURE OF NAVY OFFICER</p> <p>48. SIGNATURE OF ARMY OFFICER</p> <p>49. SIGNATURE OF AIR FORCE OFFICER</p> <p>50. SIGNATURE OF NAVY OFFICER</p> <p>51. SIGNATURE OF ARMY OFFICER</p> <p>52. SIGNATURE OF AIR FORCE OFFICER</p> <p>53. SIGNATURE OF NAVY OFFICER</p> <p>54. SIGNATURE OF ARMY OFFICER</p> <p>55. SIGNATURE OF AIR FORCE OFFICER</p> <p>56. SIGNATURE OF NAVY OFFICER</p> <p>57. SIGNATURE OF ARMY OFFICER</p> <p>58. SIGNATURE OF AIR FORCE OFFICER</p> <p>59. SIGNATURE OF NAVY OFFICER</p> <p>60. SIGNATURE OF ARMY OFFICER</p> <p>61. SIGNATURE OF AIR FORCE OFFICER</p> <p>62. SIGNATURE OF NAVY OFFICER</p> <p>63. SIGNATURE OF ARMY OFFICER</p> <p>64. SIGNATURE OF AIR FORCE OFFICER</p> <p>65. SIGNATURE OF NAVY OFFICER</p> <p>66. SIGNATURE OF ARMY OFFICER</p> <p>67. SIGNATURE OF AIR FORCE OFFICER</p> <p>68. SIGNATURE OF NAVY OFFICER</p> <p>69. SIGNATURE OF ARMY OFFICER</p> <p>70. SIGNATURE OF AIR FORCE OFFICER</p> <p>71. SIGNATURE OF NAVY OFFICER</p> <p>72. SIGNATURE OF ARMY OFFICER</p> <p>73. SIGNATURE OF AIR FORCE OFFICER</p> <p>74. SIGNATURE OF NAVY OFFICER</p> <p>75. SIGNATURE OF ARMY OFFICER</p> <p>76. SIGNATURE OF AIR FORCE OFFICER</p> <p>77. SIGNATURE OF NAVY OFFICER</p> <p>78. SIGNATURE OF ARMY OFFICER</p> <p>79. SIGNATURE OF AIR FORCE OFFICER</p> <p>80. SIGNATURE OF NAVY OFFICER</p> <p>81. SIGNATURE OF ARMY OFFICER</p> <p>82. SIGNATURE OF AIR FORCE OFFICER</p> <p>83. SIGNATURE OF NAVY OFFICER</p> <p>84. SIGNATURE OF ARMY OFFICER</p> <p>85. SIGNATURE OF AIR FORCE OFFICER</p> <p>86. SIGNATURE OF NAVY OFFICER</p> <p>87. SIGNATURE OF ARMY OFFICER</p> <p>88. SIGNATURE OF AIR FORCE OFFICER</p> <p>89. SIGNATURE OF NAVY OFFICER</p> <p>90. SIGNATURE OF ARMY OFFICER</p> <p>91. SIGNATURE OF AIR FORCE OFFICER</p> <p>92. SIGNATURE OF NAVY OFFICER</p> <p>93. SIGNATURE OF ARMY OFFICER</p> <p>94. SIGNATURE OF AIR FORCE OFFICER</p> <p>95. SIGNATURE OF NAVY OFFICER</p> <p>96. SIGNATURE OF ARMY OFFICER</p> <p>97. SIGNATURE OF AIR FORCE OFFICER</p> <p>98. SIGNATURE OF NAVY OFFICER</p> <p>99. SIGNATURE OF ARMY OFFICER</p> <p>100. SIGNATURE OF AIR FORCE OFFICER</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09776

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

Item 1 Film G23h 924/58 871

9795

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>Route 175</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		d. STREET ADDRESS <u>Fifth st., Box 161 X</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ERVY</u>		Middle <u>LEE</u>		Last <u>HAWKS</u>		4. DATE OF DEATH Month <u>Sept.</u>		Day <u>19</u>		Year <u>19 58</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 7, 1899</u>		9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Nat'l. Plastic</u>		12. CITIZEN OF WHAT COUNTRY? <u>Pettit Co., Va.</u>		13. FATHER'S NAME <u>William H. Hawks</u>		14. MOTHER'S MAIDEN NAME <u>Rhody Pucket</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>230 05 8225</u>		17. INFORMANT <u>Miss Christine Hawks</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal abdominal injuries. Comm. compound fracture</u> DUE TO <u>of right leg (below knee) fracture of left femur and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>left humerus. Multiple lacerations.</u> Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>812 X</u>		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was hit by a car while crossing route 175, Odenton, Md.</u>		22. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was hit by a car while crossing route 175, Odenton, Md.</u>	
24. TIME OF INJURY Month, Day, Year <u>6.10 A.M.</u> Hour <u>6.10</u> p.m. <u>19/58</u>		25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 175</u>		27. (City or town) <u>Odenton</u>		28. (County) <u>A.A.</u>		29. (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/19/58</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Done Run Cemetery</u>		22d. LOCATION (City, town, or county) <u>Mount Airy N.C.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Lynton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. DATE <u>SEP 22 '58</u>		26. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		27. DATE <u>SEP 22 '58</u>		28. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		29. DATE <u>SEP 22 '58</u>		30. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. (Page may be retained by the funeral director.) TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEATH CERT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Date of Birth: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

11. Signature of Physician: _____

12. Signature of Nurse: _____

13. Signature of Pathologist: _____

14. Signature of Forensic Scientist: _____

15. Signature of Toxicologist: _____

16. Signature of Anthropologist: _____

17. Signature of Radiologist: _____

18. Signature of Psychiatrist: _____

19. Signature of Social Worker: _____

20. Signature of Chaplain: _____

21. Signature of Funeral Home: _____

22. Signature of Cemetery: _____

23. Signature of Burial: _____

24. Signature of Interment: _____

25. Signature of Final Disposition: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09777

9796

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1m 22d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1813 Bentalou Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Washington Last Holmes				4. DATE OF DEATH Month 9 Day 30 Year 58					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/74			
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 8 Days 30 Hours 19 Min. 58		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George Holmes				14. MOTHER'S MAIDEN NAME Rachel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. -----					
17. INFORMANT Hospital Records				Address -----					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 422.1 DUE TO ACVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ----- DUE TO (c) -----								INTERVAL BETWEEN ONSET AND DEATH -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Senile Dementia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. ----- p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
20f. (City or town) -----				20g. (County) -----		20h. (State) -----			
21. I certify that I attended the deceased from 8/8 , 19 58 , to 9/30 , 19 58 , that I last saw the deceased alive on 9/30 , 19 58 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.					
DATE SIGNED 9/30/58									
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				Crownsville State Hospital, Md. 9/30/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/4/1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS 322		24a. REC'D BY REGISTRAR Oct 3 '58			
				24b. REGISTRAR'S SIGNATURE [Signature]					

CERTIFICATE OF DEATH

9788

MAINE STATE DEPARTMENT OF HEALTH - BATHING 10

MAINE STATE DEPARTMENT OF HEALTH - BATHING 10

<p>1. Name of deceased: <u>George Washington</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Date of death: <u>1978</u></p>	
<p>5. Place of birth: <u>Maine</u></p>		<p>6. Place of death: <u>Maine</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1978</u></p>		<p>12. Office of registration: <u>Maine</u></p>	

9797

Item 3 FilmG234 10-9-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

09778

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 301-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1956 W. Mulberry Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Vernon		Middle N.		Last Jackson	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1901	
9. AGE (In years last birthday) yrs. 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
10a.		10b.		11.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Jackson				14. MOTHER'S MAIDEN NAME Hattie Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records			
15.		16.		17.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) Chronic Brain Syndrome Associated with generalized arteriosclerosis.						INTERVAL BETWEEN ONSET AND DEATH Known to us since admission	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026X CNS Syphilis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 9/5/1958 , to 9/19/1958 , that I last saw the deceased alive on 9/19/1958 , and that death occurred at 8:33 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 9-19-58 ACTUAL SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital, Md. 9-19-58 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 9-19-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 23/58		22c. NAME OF CEMETERY OR CREMATORY mt. Auburn cem		22d. LOCATION (City, town, or county) (State) West Port - Balt. Md	
23. FUNERAL DIRECTOR'S SIGNATURE M. H. P. Funeral Home Inc. 1429 Lawrence				24a. REC'D BY REGISTRAR Sept 19/58		24b. REGISTRAR'S SIGNATURE Arthur S. H...	

7. *Thymus*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9755

CERTIFICATE OF DEATH

Reg. Dist. No.

09779

1. PLACE OF DEATH a. COUNTY Anne Arundle MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 20 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carl Middle Henry Last JONES		4. DATE OF DEATH Month SEPTEMBER Day 1 Year 19 58	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 June 1893
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 2 Days 12 Hours 40 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired USN		10b. KIND OF BUSINESS OR INDUSTRY U.S. Admiral	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Sydney M. JONES		14. MOTHER'S MAIDEN NAME Mary Jane WHITTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1, WW 11	
17. INFORMANT U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PANCREATITIS, ACUTE 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Penetrating Peptic Ulcer			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 June , 19 58 to 1 September , 19 58 , that I last saw the deceased alive on 1 September , 19 58 , and that death occurred at 12:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J.P. Connelly		M.D.	
PHYSICIAN'S NAME (Type) T. P. CONNELLY		CAPTAIN MC USN USNH, ANNAPOLIS, MD. 9-1-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/4/58	
22c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL ACADEMY		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DATE SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1. NAME OF PATIENT ANN ARTHUR		2. DATE OF BIRTH 20 JUN 1925		3. PLACE OF BIRTH ANNAPOLIS	
4. NAME OF PATIENT ANN ARTHUR		5. DATE OF BIRTH 20 JUN 1925		6. PLACE OF BIRTH ANNAPOLIS	
7. NAME OF PATIENT ANN ARTHUR		8. DATE OF BIRTH 20 JUN 1925		9. PLACE OF BIRTH ANNAPOLIS	
10. NAME OF PATIENT ANN ARTHUR		11. DATE OF BIRTH 20 JUN 1925		12. PLACE OF BIRTH ANNAPOLIS	
13. NAME OF PATIENT ANN ARTHUR		14. DATE OF BIRTH 20 JUN 1925		15. PLACE OF BIRTH ANNAPOLIS	
16. NAME OF PATIENT ANN ARTHUR		17. DATE OF BIRTH 20 JUN 1925		18. PLACE OF BIRTH ANNAPOLIS	
19. NAME OF PATIENT ANN ARTHUR		20. DATE OF BIRTH 20 JUN 1925		21. PLACE OF BIRTH ANNAPOLIS	
22. NAME OF PATIENT ANN ARTHUR		23. DATE OF BIRTH 20 JUN 1925		24. PLACE OF BIRTH ANNAPOLIS	
25. NAME OF PATIENT ANN ARTHUR		26. DATE OF BIRTH 20 JUN 1925		27. PLACE OF BIRTH ANNAPOLIS	
28. NAME OF PATIENT ANN ARTHUR		29. DATE OF BIRTH 20 JUN 1925		30. PLACE OF BIRTH ANNAPOLIS	
31. NAME OF PATIENT ANN ARTHUR		32. DATE OF BIRTH 20 JUN 1925		33. PLACE OF BIRTH ANNAPOLIS	
34. NAME OF PATIENT ANN ARTHUR		35. DATE OF BIRTH 20 JUN 1925		36. PLACE OF BIRTH ANNAPOLIS	
37. NAME OF PATIENT ANN ARTHUR		38. DATE OF BIRTH 20 JUN 1925		39. PLACE OF BIRTH ANNAPOLIS	
40. NAME OF PATIENT ANN ARTHUR		41. DATE OF BIRTH 20 JUN 1925		42. PLACE OF BIRTH ANNAPOLIS	
43. NAME OF PATIENT ANN ARTHUR		44. DATE OF BIRTH 20 JUN 1925		45. PLACE OF BIRTH ANNAPOLIS	
46. NAME OF PATIENT ANN ARTHUR		47. DATE OF BIRTH 20 JUN 1925		48. PLACE OF BIRTH ANNAPOLIS	
49. NAME OF PATIENT ANN ARTHUR		50. DATE OF BIRTH 20 JUN 1925		51. PLACE OF BIRTH ANNAPOLIS	
52. NAME OF PATIENT ANN ARTHUR		53. DATE OF BIRTH 20 JUN 1925		54. PLACE OF BIRTH ANNAPOLIS	
55. NAME OF PATIENT ANN ARTHUR		56. DATE OF BIRTH 20 JUN 1925		57. PLACE OF BIRTH ANNAPOLIS	
58. NAME OF PATIENT ANN ARTHUR		59. DATE OF BIRTH 20 JUN 1925		60. PLACE OF BIRTH ANNAPOLIS	
61. NAME OF PATIENT ANN ARTHUR		62. DATE OF BIRTH 20 JUN 1925		63. PLACE OF BIRTH ANNAPOLIS	
64. NAME OF PATIENT ANN ARTHUR		65. DATE OF BIRTH 20 JUN 1925		66. PLACE OF BIRTH ANNAPOLIS	
67. NAME OF PATIENT ANN ARTHUR		68. DATE OF BIRTH 20 JUN 1925		69. PLACE OF BIRTH ANNAPOLIS	
70. NAME OF PATIENT ANN ARTHUR		71. DATE OF BIRTH 20 JUN 1925		72. PLACE OF BIRTH ANNAPOLIS	
73. NAME OF PATIENT ANN ARTHUR		74. DATE OF BIRTH 20 JUN 1925		75. PLACE OF BIRTH ANNAPOLIS	
76. NAME OF PATIENT ANN ARTHUR		77. DATE OF BIRTH 20 JUN 1925		78. PLACE OF BIRTH ANNAPOLIS	
79. NAME OF PATIENT ANN ARTHUR		80. DATE OF BIRTH 20 JUN 1925		81. PLACE OF BIRTH ANNAPOLIS	
82. NAME OF PATIENT ANN ARTHUR		83. DATE OF BIRTH 20 JUN 1925		84. PLACE OF BIRTH ANNAPOLIS	
85. NAME OF PATIENT ANN ARTHUR		86. DATE OF BIRTH 20 JUN 1925		87. PLACE OF BIRTH ANNAPOLIS	
88. NAME OF PATIENT ANN ARTHUR		89. DATE OF BIRTH 20 JUN 1925		90. PLACE OF BIRTH ANNAPOLIS	
91. NAME OF PATIENT ANN ARTHUR		92. DATE OF BIRTH 20 JUN 1925		93. PLACE OF BIRTH ANNAPOLIS	
94. NAME OF PATIENT ANN ARTHUR		95. DATE OF BIRTH 20 JUN 1925		96. PLACE OF BIRTH ANNAPOLIS	
97. NAME OF PATIENT ANN ARTHUR		98. DATE OF BIRTH 20 JUN 1925		99. PLACE OF BIRTH ANNAPOLIS	
100. NAME OF PATIENT ANN ARTHUR		101. DATE OF BIRTH 20 JUN 1925		102. PLACE OF BIRTH ANNAPOLIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9798

CERTIFICATE OF DEATH

09780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>		d. STREET ADDRESS <u>1205 Kuethe Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 Kuethe Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie Bernadette Jones</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Owen F. Murray</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Jane Cady</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Mildred M. Jones</u> Address <u>Same As Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Dis.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 23</u> , 19 <u>58</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u> DATE SIGNED <u>9-25-58</u> ACTUAL SIGNATURE <u>C. R. MacDonald M.D.</u> M.D. <u>R. O. H. Harris M.D.</u> PHYSICIAN'S NAME (Type) <u>C. R. MacDonald M.D.</u> <u>Glen Burnie Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 23, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

CERTIFICATE OF DEATH

2028

RECEIVED
JAN 10 1918
BALTIMORE

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. BROWN		45		M		W		JAN 10 1873		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 10 1918		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SIGNED BY	
JAMES M. BROWN		MARY J. BROWN		HIGH SCHOOL		METHODIST		MARRIED		J. M. BROWN	
DATE OF INTERVIEW		BY WHOM INTERVIEWED		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
JAN 10 1918		J. M. BROWN									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9799

CERTIFICATE OF DEATH

Reg. Dist. No.

09781

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XSevern</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Telegraph Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Telegraph Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>MAE</u> Last <u>KNIGHT</u>		4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hammond</u>		14. MOTHER'S MAIDEN NAME <u>Marjary (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	
17. INFORMANT Address <u>Mr. Alfonso J. Knight</u>		Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Diabetic Gangrene</u> DUE TO (b) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> 19 <u>46</u> to <u>Sept 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 12</u> , 19 <u>58</u> , and that death occurred at <u>2:56 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward G. Skeritt</u> M.D.		ADDRESS (Street, city or town, state) <u>Cambria Md</u> DATE SIGNED <u>9-15-58</u>	
PHYSICIAN'S NAME (Type) <u>Edward G. Skeritt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nickols-Bethel Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Odenton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Wright</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. If no burial, cremation, or removal, file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9800

Reg. Dist. No. 09782

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN TB <u>1 hr</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hanover</u>		d. STREET ADDRESS <u>Box 235 Maple Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. A. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LESLIE</u> Middle <u>BRUCE</u> Last <u>KNOTT</u>		4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 23 1939</u>
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy man.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Olen Knott</u>		14. MOTHER'S MAIDEN NAME <u>Avis Francie Foley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Herman Olen Knott (father)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>835X</u> IMMEDIATE CAUSE (a) <u>Fracture of skull and multiple lacerations of</u> DUE TO <u>body.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off a farm type tractor to a gravel road.</u>	
20c. TIME OF INJURY Month <u>10</u> Day <u>9</u> Year <u>1958</u> Hour <u>0715</u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Golf Course</u>		20f. (City or town) (County) (State) <u>Fort Meade Anne Arundel Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		DATE SIGNED <u>9/20/58</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-23-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Hgby. Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Kenny, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>9/22/58</u>	
ADDRESS <u>1600 hollins street</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Khan</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8400

<p>1. Name of Deceased: <i>John A. Smith</i></p>		<p>2. Date of Death: <i>11/10/58</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Sex: <i>Male</i></p>	
<p>5. Race: <i>White</i></p>		<p>6. Marital Status: <i>Married</i></p>	
<p>7. Occupation: <i>Teacher</i></p>		<p>8. Residence: <i>123 Main St, Baltimore, Md.</i></p>	
<p>9. Cause of Death: <i>Myocardial Infarction</i></p>			
<p>10. Manner of Death: <i>Natural</i></p>			
<p>11. Signature of Medical Examiner: <i>Robert D. Jones</i></p>			

RECEIVED
BALTIMORE
NOV 11 1958

9801

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ralph Middle Knox Last Knox				4. DATE OF DEATH Month 9 Day 5 Year 19 58			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1871	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Aortic Regurgitation - probably luetic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Decubitus Ulcers - Lower gastrointestinal hemorrhage DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown			
20c. TIME OF INJURY Hour a. m. 19 p. m. 19 Month 9 Day 5 Year 1958				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown				20f. (City or town) (County) (State) Unknown			
21. I certify that I attended the deceased from 8/29 , 19 58 , to 9/5 , 19 58 , that I last saw the deceased alive on 9/5 , 19 58 , and that death occurred at 4:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 9-8-58 ACTUAL SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital, Md. 9-8-58 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 9-8-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept 9, 1958			
22c. NAME OF CEMETERY OR CREMATORY Unknown				22d. LOCATION (City, town, or county) (State) Baltimore Md			
23. FUNERAL DIRECTOR'S SIGNATURE Choy O Wilson				24a. REC'D BY REGISTRAR DATE SEP 9 1958			
24b. REGISTRAR'S SIGNATURE Arthur S. Muesel							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		45		Jan 15 1901		Baltimore, Md.	
Cause of death		Disease		Symptoms		Time of death		Physician	
Heart failure		Myocarditis		Chest pain		10:30 AM		Dr. J. Smith	
Occupation		Education		Religion		Marital status		Burial place	
Clerk		High School		Catholic		Married		St. Mary's Church	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of certificate		Place of certificate		Name of registrar		Name of informant		Name of witness	
Jan 16 1901		Baltimore, Md.		John Doe		John Doe		John Doe	

9802

CERTIFICATE OF DEATH

Reg. Dist. No.

09784

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN 1b X SEVERNA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARIE Middle JOCHEN Last KROGER		4. DATE OF DEATH Month September Day 9 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 21, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT JOCHEN		14. MOTHER'S MAIDEN NAME MARY WALTERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT WILLIAM F. KROGER #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of the Liver 156.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Primary site undetermined DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. Month 19 Day 19 Year 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 4 , 19 58 , to Sept. 9 , 19 58 , that I last saw the deceased alive on Sept. 9 , 19 58 , and that death occurred at 3:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis I. Codd		ADDRESS (Street, city or town, state) Severna Park, Maryland	
DATE SIGNED 9-9-58			
PHYSICIAN'S NAME (Type) Francis I. Codd M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF SEPT 11, 1958	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE CO. MD
23. FUNERAL DIRECTOR'S SIGNATURE John M Taylor		ADDRESS Son Annapolis Md	
24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Charles L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2802

1. NAME OF DECEASED JAMES J. HARRIS		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 1918		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Pneumonia	
7. DATE OF BIRTH 1873		8. PLACE OF BIRTH Boston		9. OCCUPATION Carpenter	
10. MARITAL STATUS Married		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. PRESENT ADDRESS 123 Main St, Boston		14. DATE OF DEATH 1918		15. PLACE OF DEATH Home	
16. CAUSE OF DEATH Pneumonia		17. DATE OF DEATH 1918		18. PLACE OF DEATH Home	
19. PRESENT ADDRESS 123 Main St, Boston		20. DATE OF DEATH 1918		21. PLACE OF DEATH Home	
22. CAUSE OF DEATH Pneumonia		23. DATE OF DEATH 1918		24. PLACE OF DEATH Home	
25. PRESENT ADDRESS 123 Main St, Boston		26. DATE OF DEATH 1918		27. PLACE OF DEATH Home	
28. CAUSE OF DEATH Pneumonia		29. DATE OF DEATH 1918		30. PLACE OF DEATH Home	
31. PRESENT ADDRESS 123 Main St, Boston		32. DATE OF DEATH 1918		33. PLACE OF DEATH Home	
34. CAUSE OF DEATH Pneumonia		35. DATE OF DEATH 1918		36. PLACE OF DEATH Home	
37. PRESENT ADDRESS 123 Main St, Boston		38. DATE OF DEATH 1918		39. PLACE OF DEATH Home	
40. CAUSE OF DEATH Pneumonia		41. DATE OF DEATH 1918		42. PLACE OF DEATH Home	
43. PRESENT ADDRESS 123 Main St, Boston		44. DATE OF DEATH 1918		45. PLACE OF DEATH Home	
46. CAUSE OF DEATH Pneumonia		47. DATE OF DEATH 1918		48. PLACE OF DEATH Home	
49. PRESENT ADDRESS 123 Main St, Boston		50. DATE OF DEATH 1918		51. PLACE OF DEATH Home	
52. CAUSE OF DEATH Pneumonia		53. DATE OF DEATH 1918		54. PLACE OF DEATH Home	
55. PRESENT ADDRESS 123 Main St, Boston		56. DATE OF DEATH 1918		57. PLACE OF DEATH Home	
58. CAUSE OF DEATH Pneumonia		59. DATE OF DEATH 1918		60. PLACE OF DEATH Home	
61. PRESENT ADDRESS 123 Main St, Boston		62. DATE OF DEATH 1918		63. PLACE OF DEATH Home	
64. CAUSE OF DEATH Pneumonia		65. DATE OF DEATH 1918		66. PLACE OF DEATH Home	
67. PRESENT ADDRESS 123 Main St, Boston		68. DATE OF DEATH 1918		69. PLACE OF DEATH Home	
70. CAUSE OF DEATH Pneumonia		71. DATE OF DEATH 1918		72. PLACE OF DEATH Home	
73. PRESENT ADDRESS 123 Main St, Boston		74. DATE OF DEATH 1918		75. PLACE OF DEATH Home	
76. CAUSE OF DEATH Pneumonia		77. DATE OF DEATH 1918		78. PLACE OF DEATH Home	
79. PRESENT ADDRESS 123 Main St, Boston		80. DATE OF DEATH 1918		81. PLACE OF DEATH Home	
82. CAUSE OF DEATH Pneumonia		83. DATE OF DEATH 1918		84. PLACE OF DEATH Home	
85. PRESENT ADDRESS 123 Main St, Boston		86. DATE OF DEATH 1918		87. PLACE OF DEATH Home	
88. CAUSE OF DEATH Pneumonia		89. DATE OF DEATH 1918		90. PLACE OF DEATH Home	
91. PRESENT ADDRESS 123 Main St, Boston		92. DATE OF DEATH 1918		93. PLACE OF DEATH Home	
94. CAUSE OF DEATH Pneumonia		95. DATE OF DEATH 1918		96. PLACE OF DEATH Home	
97. PRESENT ADDRESS 123 Main St, Boston		98. DATE OF DEATH 1918		99. PLACE OF DEATH Home	
100. CAUSE OF DEATH Pneumonia		101. DATE OF DEATH 1918		102. PLACE OF DEATH Home	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09785

9803

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beauty Beach</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 34014 d. STREET ADDRESS <u>419 S. Ellwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph Kuc</u> (<u>Kutz</u>) First Middle Last			4. DATE OF DEATH <u>September 14th.</u> 19 <u>58</u> Month Day Year				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/89</u>		9. AGE (In years last birthday) <u>69</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired tavern keeper.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland, Europe.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>?</u>				
14. MOTHER'S MAIDEN NAME <u>?</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <u>Leo Buscemi (son in law) 1506-E. 36th St.</u>			17. INFORMANT <u>Baltimore.</u> <u>Leo Buscemi (son in law) 1506-E. 36th St.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/14/58</u>			DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>			
22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozagowski</u>			ADDRESS <u>1930 Eastern</u>				
24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Filing 234 10-14-58 et

9756

CERTIFICATE OF DEATH

09786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>X Harwood</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A General</i>		d. STREET ADDRESS <i>1 Weston Farm</i>	
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>Estis</i> Last <i>Lankford</i>		4. DATE OF DEATH Month <i>sept</i> Day <i>30</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1871</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>aa Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Richard Tillard</i>		14. MOTHER'S MAIDEN NAME <i>Estis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Richard E Lankford</i>	
17. INFORMANT <i>Richard E Lankford</i>		Address <i>Annapolis Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery disease</i> DUE TO (c) <i>Pulmonary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-26</i> , 19 <i>58</i> , to <i>Sept 30</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 30</i> , 19 <i>58</i> , and that death occurred at <i>10 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Emily H. Wiers</i>		DATE SIGNED <i>9-30-58</i>	
PHYSICIAN'S NAME (Type) <i>Arthur S. Lankford</i>		M.D. <i>Latham, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 2-1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St James Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Tracys Landing aa Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 6 '58</i>	
ADDRESS <i>Annapolis, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Lankford</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09787

9804

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN lb <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>410 Irene Ave</u>		d. STREET ADDRESS <u>410 Irene Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALBERT Andrew Leggett</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert S. Leggett</u>		14. MOTHER'S MAIDEN NAME <u>Trogasser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-11069</u>	
17. INFORMANT <u>Wife Mrs Leggett</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19____, to <u>1958</u> , 19____, that I last saw the deceased alive on <u>Sept 12</u> , 19____, and that death occurred at <u>5:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park md</u>	
DATE SIGNED <u>9-22-58</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Severna Park md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 25, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

1903

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Occupation</p>		<p>7. Cause of death</p>		<p>8. Date of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Date of registration</p>	
<p>13. Name of informant</p>		<p>14. Address of informant</p>		<p>15. Name of registrar</p>		<p>16. Address of registrar</p>	
<p>17. Name of physician</p>		<p>18. Address of physician</p>		<p>19. Name of informant</p>		<p>20. Address of informant</p>	
<p>21. Name of registrar</p>		<p>22. Address of registrar</p>		<p>23. Name of informant</p>		<p>24. Address of informant</p>	
<p>25. Name of physician</p>		<p>26. Address of physician</p>		<p>27. Name of informant</p>		<p>28. Address of informant</p>	
<p>29. Name of registrar</p>		<p>30. Address of registrar</p>		<p>31. Name of informant</p>		<p>32. Address of informant</p>	
<p>33. Name of physician</p>		<p>34. Address of physician</p>		<p>35. Name of informant</p>		<p>36. Address of informant</p>	
<p>37. Name of registrar</p>		<p>38. Address of registrar</p>		<p>39. Name of informant</p>		<p>40. Address of informant</p>	
<p>41. Name of physician</p>		<p>42. Address of physician</p>		<p>43. Name of informant</p>		<p>44. Address of informant</p>	
<p>45. Name of registrar</p>		<p>46. Address of registrar</p>		<p>47. Name of informant</p>		<p>48. Address of informant</p>	
<p>49. Name of physician</p>		<p>50. Address of physician</p>		<p>51. Name of informant</p>		<p>52. Address of informant</p>	
<p>53. Name of registrar</p>		<p>54. Address of registrar</p>		<p>55. Name of informant</p>		<p>56. Address of informant</p>	
<p>57. Name of physician</p>		<p>58. Address of physician</p>		<p>59. Name of informant</p>		<p>60. Address of informant</p>	
<p>61. Name of registrar</p>		<p>62. Address of registrar</p>		<p>63. Name of informant</p>		<p>64. Address of informant</p>	
<p>65. Name of physician</p>		<p>66. Address of physician</p>		<p>67. Name of informant</p>		<p>68. Address of informant</p>	
<p>69. Name of registrar</p>		<p>70. Address of registrar</p>		<p>71. Name of informant</p>		<p>72. Address of informant</p>	
<p>73. Name of physician</p>		<p>74. Address of physician</p>		<p>75. Name of informant</p>		<p>76. Address of informant</p>	
<p>77. Name of registrar</p>		<p>78. Address of registrar</p>		<p>79. Name of informant</p>		<p>80. Address of informant</p>	
<p>81. Name of physician</p>		<p>82. Address of physician</p>		<p>83. Name of informant</p>		<p>84. Address of informant</p>	
<p>85. Name of registrar</p>		<p>86. Address of registrar</p>		<p>87. Name of informant</p>		<p>88. Address of informant</p>	
<p>89. Name of physician</p>		<p>90. Address of physician</p>		<p>91. Name of informant</p>		<p>92. Address of informant</p>	
<p>93. Name of registrar</p>		<p>94. Address of registrar</p>		<p>95. Name of informant</p>		<p>96. Address of informant</p>	
<p>97. Name of physician</p>		<p>98. Address of physician</p>		<p>99. Name of informant</p>		<p>100. Address of informant</p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A A General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Herold Harbor</u> d. STREET ADDRESS <u>Crownsville P.O.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>P.</u> Last <u>MALLOY</u>		4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Sgt U.S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret Sgt U.S.A</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Peter Malloy</u>		14. MOTHER'S MAIDEN NAME <u>Mary S. Farrell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>yes</u> <u>W war II</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Viola K. Malloy</u> Address <u> </u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DATE SIGNED <u>9/8/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside AVALON SHORES			c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ X Shadyside AVALON SHORES		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lerch & Oak Streets				d. STREET ADDRESS Lerch & Oak Streets		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DONADD Middle HOWARD Last MANNING, JR.				4. DATE OF DEATH Month Sept. Day 18 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/19/58	
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald Howard Manning, Sr.				14. MOTHER'S MAIDEN NAME Martha Jean Claxton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Donald H. Manning, Sr., Lerch & Oak Sts. Avalon Shores, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonitis 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles S. Petty</i>				DATE SIGNED 9/19/58			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/20/58		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>				ADDRESS SILVER SPRING, MD.			
24a. REC'D BY REGISTRAR DATE SEP 22 '58				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

MEDICAL CERTIFICATION

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2

2

9VVVVVVVVVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9806

CERTIFICATE OF DEATH

Reg. Dist. No.

09790

1. PLACE OF DEATH a. COUNTY <u>ANNE-Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GANN'S-Nursing Home</u>		e. STREET ADDRESS <u>Hanover-Pike</u>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>Edward</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1883</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE-Road</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>	
11. BIRTHPLACE (State or foreign country) <u>Pikesville-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Martin</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Logue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-10-0905</u>	
17. INFORMANT <u>Mary-V-Sann</u>		Address <u>millersville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Comp. - Diabetic</u> DUE TO (c) <u>Hypertension and Cardiac Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 2-58</u> to <u>Sept 19-58</u> , that I last saw the deceased alive on <u>Sept 19-58</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		DATE SIGNED <u>9-20-58</u>	
PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKEY</u>			
22a. BURIAL, CREMATION, OR OTHER REMOVAL (Specify) <u>Burial</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Finksburg</u>	
22c. LOCATION (City, town, or county) (State) <u>Finksburg, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F.Eline & Sons, Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9758

CERTIFICATE OF DEATH

Reg. Dist. No.

09791

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>110 Cedar St. (Dorchester)</u>		d. STREET ADDRESS <u>15 C. C. Terrace</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sharon Elaine McEOWANS</u>		4. DATE OF DEATH Month Day Year <u>9</u> <u>18</u> <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1957</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis McEowans</u>		14. MOTHER'S MAIDEN NAME <u>Nabmi Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Louis McEowans - Annapolis, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho-Pneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/15/58 10:00 PM</u> , to <u>9/18/58 11:00 AM</u> , that I last saw the deceased alive on <u>9/15/58</u> , 19 <u>58</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		DATE SIGNED <u>9/19/58</u>	
PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON M.D.</u>		ADDRESS (Street, city or town, state) <u>110 Cedar St. Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9807

CERTIFICATE OF DEATH

09792

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 Brownshide Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hattie Magdalene Mentecki</u>		4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10.22.1884</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ignatius Christopher</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>111-111-1111</u>	
17. INFORMANT <u>Son: Edmund Mentecki</u>		Address <u>404 Crain Highway</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8:00</u> , 19 <u>58</u> , to <u>6:30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3 Crain Highway, Glen Burnie Md.</u> DATE SIGNED <u>9.20.58</u> ACTUAL SIGNATURE <u>Andrew D. Szabo</u> M.D. PHYSICIAN'S NAME (Type) <u>Andrew D. Szabo</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, P.D., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09793

1. PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>ANNE ARUNDEL</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MILLERSVILLE</i>		c. LENGTH OF STAY IN 1b <i>18 MO.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SANN'S-NURSING-Home-Cecil-Rd. MILLERSVILLE MD.</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Elizabeth</i> Last <i>Mitchell</i>		4. DATE OF DEATH Month <i>9</i> - Day <i>30</i> - Year <i>58</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-31-1879</i>
9. AGE (In years last birthday) <i>78 1/2</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Herman-Mietzsch</i>		14. MOTHER'S MAIDEN NAME <i>Bertha-SNITSPAHN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT Address <i>Mary-V-SANN Cecil-Rd. Millersville MD.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Double Pts. Pneumonia</i> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i>11</i> Day <i>19</i> Year <i>58</i> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-11-58</i> to <i>9-30-58</i> , that I last saw the deceased alive on <i>9-30-58</i> , at <i>8 P</i> M., and that death occurred at <i>8 P</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>October 9, 1958</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSEY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>Oct 1, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Woodfield</i>		22d. LOCATION (City, town or county) (State) <i>Walesville Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward J. Hardisty</i> ADDRESS <i>Salisbury</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 6 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>John S. Kiser</i>	

1. NAME OF DECEASED JAMES W. WHITE		2. PLACE OF DEATH MILLERSVILLE, MD.	
3. DATE OF DEATH 10-31-1927		4. TIME OF DEATH 10:30 AM	
5. NAME OF NEXT OF KIN JAMES W. WHITE		6. ADDRESS OF NEXT OF KIN 1000 N. 10th St., Philadelphia, Pa.	
7. NAME OF PHYSICIAN J. H. Smith		8. NAME OF FUNERAL HOME J. H. Smith	
9. NAME OF CEMETERY Mount Airy		10. NAME OF MINISTER J. H. Smith	
11. NAME OF BURIAL PLACE Mount Airy		12. NAME OF INTERMENT J. H. Smith	
13. NAME OF COFFIN J. H. Smith		14. NAME OF CASKET J. H. Smith	
15. NAME OF CASKET J. H. Smith		16. NAME OF CASKET J. H. Smith	
17. NAME OF CASKET J. H. Smith		18. NAME OF CASKET J. H. Smith	
19. NAME OF CASKET J. H. Smith		20. NAME OF CASKET J. H. Smith	
21. NAME OF CASKET J. H. Smith		22. NAME OF CASKET J. H. Smith	
23. NAME OF CASKET J. H. Smith		24. NAME OF CASKET J. H. Smith	
25. NAME OF CASKET J. H. Smith		26. NAME OF CASKET J. H. Smith	
27. NAME OF CASKET J. H. Smith		28. NAME OF CASKET J. H. Smith	
29. NAME OF CASKET J. H. Smith		30. NAME OF CASKET J. H. Smith	
31. NAME OF CASKET J. H. Smith		32. NAME OF CASKET J. H. Smith	
33. NAME OF CASKET J. H. Smith		34. NAME OF CASKET J. H. Smith	
35. NAME OF CASKET J. H. Smith		36. NAME OF CASKET J. H. Smith	
37. NAME OF CASKET J. H. Smith		38. NAME OF CASKET J. H. Smith	
39. NAME OF CASKET J. H. Smith		40. NAME OF CASKET J. H. Smith	
41. NAME OF CASKET J. H. Smith		42. NAME OF CASKET J. H. Smith	
43. NAME OF CASKET J. H. Smith		44. NAME OF CASKET J. H. Smith	
45. NAME OF CASKET J. H. Smith		46. NAME OF CASKET J. H. Smith	
47. NAME OF CASKET J. H. Smith		48. NAME OF CASKET J. H. Smith	
49. NAME OF CASKET J. H. Smith		50. NAME OF CASKET J. H. Smith	
51. NAME OF CASKET J. H. Smith		52. NAME OF CASKET J. H. Smith	
53. NAME OF CASKET J. H. Smith		54. NAME OF CASKET J. H. Smith	
55. NAME OF CASKET J. H. Smith		56. NAME OF CASKET J. H. Smith	
57. NAME OF CASKET J. H. Smith		58. NAME OF CASKET J. H. Smith	
59. NAME OF CASKET J. H. Smith		60. NAME OF CASKET J. H. Smith	
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65. NAME OF CASKET J. H. Smith		66. NAME OF CASKET J. H. Smith	
67. NAME OF CASKET J. H. Smith		68. NAME OF CASKET J. H. Smith	
69. NAME OF CASKET J. H. Smith		70. NAME OF CASKET J. H. Smith	
71. NAME OF CASKET J. H. Smith		72. NAME OF CASKET J. H. Smith	
73. NAME OF CASKET J. H. Smith		74. NAME OF CASKET J. H. Smith	
75. NAME OF CASKET J. H. Smith		76. NAME OF CASKET J. H. Smith	
77. NAME OF CASKET J. H. Smith		78. NAME OF CASKET J. H. Smith	
79. NAME OF CASKET J. H. Smith		80. NAME OF CASKET J. H. Smith	
81. NAME OF CASKET J. H. Smith		82. NAME OF CASKET J. H. Smith	
83. NAME OF CASKET J. H. Smith		84. NAME OF CASKET J. H. Smith	
85. NAME OF CASKET J. H. Smith		86. NAME OF CASKET J. H. Smith	
87. NAME OF CASKET J. H. Smith		88. NAME OF CASKET J. H. Smith	
89. NAME OF CASKET J. H. Smith		90. NAME OF CASKET J. H. Smith	
91. NAME OF CASKET J. H. Smith		92. NAME OF CASKET J. H. Smith	
93. NAME OF CASKET J. H. Smith		94. NAME OF CASKET J. H. Smith	
95. NAME OF CASKET J. H. Smith		96. NAME OF CASKET J. H. Smith	
97. NAME OF CASKET J. H. Smith		98. NAME OF CASKET J. H. Smith	
99. NAME OF CASKET J. H. Smith		100. NAME OF CASKET J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9759

CERTIFICATE OF DEATH

09794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annabellis</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel Gen'l Hospital</i>		d. STREET ADDRESS <i>Rt. 1 - Box 387-</i>	
3. NAME OF DECEASED (Type or print) First <i>Emma</i> Middle Last <i>Moore</i>		4. DATE OF DEATH Month <i>September</i> Day <i>21</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 4, 1905</i>
9. AGE (in years last birthday) <i>52</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Rosehill, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lafette Hounshell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hounshell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. William E. Moore</i>		Address <i>Same As #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac dilatation</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>hypertensive cardiovascular disease</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>57</i> , to <i>Sept</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 24</i> , 19 <i>58</i> , and that death occurred at <i>9:09 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>S. Borosuck</i> M.D.		ADDRESS (Street, city or town, state) <i>Glen Burnie, Md.</i> DATE SIGNED <i>9/21/58</i>	
PHYSICIAN'S NAME (Type) <i>S. Borosuck M.D.</i>		<i>Ann Arundel, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 24, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. L. Layton</i>		ADDRESS <i>Glen Burnie, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 25 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Film G234 9/24/58 ggi

09795

9809

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	c. LENGTH OF STAY IN lb 3 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS 630 Saratoga West.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Thomas Middle L. Last Nelson		4. DATE OF DEATH Month September Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 4, 1895
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 6 Days 3	IF UNDER 24 HRS. Hours 3 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY Entertainment	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Unkn	
14. MOTHER'S MAIDEN NAME Unkn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 522X DUE TO Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hypostatic pneumonia (c) 5 days		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/12 , 19 58 to 9/13 , 19 58 , that I last saw the deceased alive on 9/13/58 , 19 58 , and that death occurred at 10:45 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. B.		ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED September 15, 1958	
PHYSICIAN'S NAME (Type) L. B.		M.D. Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sept 25/58	22b. DATE THEREOF 9/18/58	22c. NAME OF CEMETERY OR CREMATORY Balto Nat. Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Edward Rimbault		24a. RECORD BY REGISTRAR SEP 15 '58	
ADDRESS 14637 N. Carey St		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

1903

82 8/12

974

1/6

82 8/12

10-12-1903
 10-12-1903
 10-12-1903

10-12-1903

10-12-1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. File #13 P-25
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9760

CERTIFICATE OF DEATH

09796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3Y01-4</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL County Gen'l Hosp.</u>				d. STREET ADDRESS <u>29 S. BERNICE AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CATHERINE</u> First <u>CECELIA</u> Middle <u>NETHKEN</u> Last				4. DATE OF DEATH <u>SEPT. 26, 1958</u> Month <u>SEPT.</u> Day <u>26</u> Year <u>1958</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 7, 1907</u>			
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>PATRICK McTAGUE</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN SLATTERY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CHARLES NETHKEN</u> Address <u>29 S. BERNICE AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>obstructive jaundice sec. hepato-</u> <u>581.1</u> DUE TO <u>cellular d. upon Lameris cirrhosis?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>									
21. I certify that I attended the deceased from <u>9-26-58</u> , 19 <u>58</u> , to <u>9-26-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-26-58</u> , 19 <u>58</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.				ADDRESS (Street, city or town, state) <u>121 Cathedral St - Baltimore</u> DATE SIGNED <u>9-26-58</u>					
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u> <u>Annapolis, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schuch</u> ADDRESS <u>2101 Frederick Ave</u>				24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1920

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Jan 15 1920</i>		5. PLACE OF DEATH <i>Home</i>	
6. OCCUPATION <i>Teacher</i>		7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MEDICAL HISTORY <i>None</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>		13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>		25. SIGNATURE OF DECEASED <i>John Doe</i>	
26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>	
36. SIGNATURE OF DECEASED <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>		49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF DECEASED <i>John Doe</i>	
56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>	
66. SIGNATURE OF DECEASED <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>		73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>		85. SIGNATURE OF DECEASED <i>John Doe</i>	
86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>	
96. SIGNATURE OF DECEASED <i>John Doe</i>		97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09797

9810

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 20y 7m 29d			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital			d. STREET ADDRESS 3001.4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Rena Middle Norwood Last Norwood			4. DATE OF DEATH Month 9 Day 11 Year 19 58		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) -----	
13. FATHER'S NAME -----			14. MOTHER'S MAIDEN NAME -----		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia with Undetermined organism DUE TO (c) -----					INTERVAL BETWEEN ONSET AND DEATH -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) ----- (County) ----- (State) -----					
21. I certify that I attended the deceased from 9-10- , 19 58 , to 9/11 , 19 58 , that I last saw the deceased alive on 9/11/ , 19 58 , and that death occurred at 7:10 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Konstantin Weber		M.D. Crownsville State Hospital, Md.		DATE SIGNED 9/11/58	
PHYSICIAN'S NAME (Type) K. Weber, M. D.		Crownsville State Hospital, Md.		9/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-12-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's	
22d. LOCATION (City, town, or county) Balto, Md.		(State) -----			
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md.			ADDRESS -----		24a. REC'D BY REGISTRAR DATE SEP 16 '58
			24b. REGISTRAR'S SIGNATURE Charles E. House		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9761

CERTIFICATE OF DEATH

09798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. General Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Joseph First Parker Middle Last				4. DATE OF DEATH Month 9 Day 2 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 14 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Comberstone		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Isaac			14. MOTHER'S MAIDEN NAME Catherine				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Susanna Parker Shadyside Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-29-58 , 19____, to 9-29-58 , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A.T. Allen M.D.				DATE SIGNED 6-1 Cathedral St 9-15-58			
PHYSICIAN'S NAME (Type) A T ALLEN				Amroglen Ave			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/58		22c. NAME OF CEMETERY OR CREMATORY Ebenzer		22d. LOCATION (City, town, or county) (State) Hootesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Burdette Hootesville Md				24a. REC'D BY REGISTRAR DATE SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		DATE OF BIRTH [Handwritten: Jan 15, 1900]		PLACE OF DEATH [Handwritten: Baltimore, Md.]	
OCCUPATION [Handwritten: Clerk]		CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]	
DATE OF DEATH [Handwritten: Feb 10, 1945]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF INTERMENT [Handwritten: St. Mary's Cemetery]	
SIGNATURE OF PHYSICIAN [Handwritten: J. H. Smith]		SIGNATURE OF CLERK [Handwritten: A. B. Jones]		SIGNATURE OF WITNESS [Handwritten: C. D. Brown]	
CERTIFICATE OF DEATH [Handwritten: This is to certify that the above named person died on the 10th day of February, 1945, at the age of 45 years, of Heart Disease, a natural cause of death.]		I hereby certify that the above named person died on the 10th day of February, 1945, at the age of 45 years, of Heart Disease, a natural cause of death.		I hereby certify that the above named person died on the 10th day of February, 1945, at the age of 45 years, of Heart Disease, a natural cause of death.	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md., and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9811

CERTIFICATE OF DEATH

Reg. Dist. No.

09799

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREEN HAVEN</u>		c. LENGTH OF STAY IN 1b <u>14 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREEN HAVEN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7 TH STREET</u>				d. STREET ADDRESS <u>7 TH STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH ANNA PECORARO</u>				4. DATE OF DEATH Month Day Year <u>SEPT 3 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 5, 1904</u>	
9. AGE (In years last birthday) yrs. <u>54</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN LOTZ</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE CUNEO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HUSBAND</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LUNGS</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA UTERUS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET OF DEATH <u>3 MONTHS</u> <u>9 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 1, 1957</u> , to <u>SEPT. 3, 1958</u> , that I last saw the deceased alive on <u>SEPT. 1, 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>RIVIERA BEACH</u>		DATE SIGNED <u>9/3/58</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				ADDRESS <u>PASADENA, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>SEP 4 8 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. J. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 5 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9812

CERTIFICATE OF DEATH

Reg. Dist. No.

09800

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>9 yrs. 3m</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1315 Ashland Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thelma</u> Middle <u>Penry</u> Last <u>Penry</u>				4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/9/02</u>	9. AGE (In years lost birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Penry (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Fanniie Johnson (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>141.9</u> IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the tongue</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia, Undifferentiated Type</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>6/18</u> , 19 <u>58</u> , to <u>9/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/18/</u> , 19 <u>58</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>9/18/58</u>							
ACTUAL SIGNATURE <u>L. Benedict, M.D.</u>				M.D. <u>Crownsville State Hospital, Md.</u> <u>9/18/58</u>			
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>				<u>Crownsville State Hospital, Md.</u> <u>9/18/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>9. 19. 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mellian Reese #2 10894 9th St. N.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>SEP 24 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

CERTIFICATE OF DEATH

1912

RECORD

Handwritten signature or mark.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9813
CERTIFICATE OF DEATH

09801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CALVERT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. LENGTH OF STAY IN 1b 4 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL		d. STREET ADDRESS DOWELL 04X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last (LORIN) LOWNDES PHILLIPS		4. DATE OF DEATH Month Day Year 9 15 1958	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/96
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD PHILLIPS		14. MOTHER'S MAIDEN NAME CHRISTINA WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W.I.		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 5/8/	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 58 9/15/		20f. (City or town) (County) (State) 58	
21. I certify that I attended the deceased from 5/8/1958, 7:00 A.M., that I last saw the deceased alive on 9/15/1958, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Benedict, M. D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	
DATE SIGNED 9/15/58		DATE SIGNED 9/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 18, 1958	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L Russ		ADDRESS 2222 N north ave.	
24a. REC'D BY REGISTRAR DATE 9/19/58		24b. REGISTRAR'S SIGNATURE Arthur S. Khanna	

1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9762

CERTIFICATE OF DEATH

Reg. Dist. No.

09802

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHALK PT. MD</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 day</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First <u>MAY</u> Middle <u>PHIPPS</u> Last		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>CHALK PT. MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Rivch ner</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH WALKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Russell E. Phipps</u>		Address <u>West River P.O.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery atherosclerosis</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260 Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 seconds</u> <u>5 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Sept 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>58</u> , and that death occurred at <u>4:00</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John L. Brademan</u>		DATE SIGNED <u>9/5/58</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 7 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodford</u>		22d. LOCATION (City, town or county) (State) <u>Galesville MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Redduty Galesville Md</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Charles S. Huns</u>	

CERTIFICATE OF DEATH

PLACE OF BIRTH (State, County, and City or Town)		PLACE OF DEATH (State, County, and City or Town)	
DATE OF BIRTH (Month, Day, and Year)		DATE OF DEATH (Month, Day, and Year)	
SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		RACE White <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/>	
OCCUPATION (If deceased was engaged in any occupation at the time of death)		CAUSE OF DEATH (If known, state the cause of death)	
SIGNATURE OF DECEASED (If known, sign name)		SIGNATURE OF WITNESSES (If known, sign names)	
SIGNATURE OF PHYSICIAN (If known, sign name)		SIGNATURE OF CORONER (If known, sign name)	
SIGNATURE OF JUDGE (If known, sign name)		SIGNATURE OF CLERK (If known, sign name)	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 13, 14, Film 0234 9/24/58 gsj
9763 CERTIFICATE OF DEATH

09803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b X Marley Park- Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL		d. STREET ADDRESS 20 Greenway Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD PLEWS		4. DATE OF DEATH Month Day Year SEPTEMBER 14 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron worker		10b. KIND OF BUSINESS OR INDUSTRY ship yrd.	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Plevs		14. MOTHER'S MAIDEN NAME Jane (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 215-01-3222A	
17. INFORMANT Harrett Plevs- Wife- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6/26/58 9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had several previous attacks.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/26/58 , 19 58 , to 9/14 , 19 58 , that I last saw the deceased alive on 9/13/58 , 19 58 , and that death occurred at 8:50 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Maurice Klawans M.D.		ADDRESS (Street, city or town, state) 31 Southgate Ave. Annapolis, Md.	
DATE SIGNED 9/16/58			
PHYSICIAN'S NAME (Type) Maurice Klawans MD		Southgate Ave. Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-17-58	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	22d. LOCATION (City, town, or county) (State) Howard County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING AND KIRKLEY		24a. REC'D BY REGISTRAR SEP 18 '58	
ADDRESS Glen Burnie, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

9814

CERTIFICATE OF DEATH

Reg. Dist. No.

09805

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrettton Manor's mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Severna Park Md</u>		d. STREET ADDRESS <u>md</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Franklin Jacob Rhodes</u>		4. DATE OF DEATH Month Day Year <u>9-10 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 13 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist - Machine Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High House Penn U.S.</u>	
11. BIRTHPLACE (State or foreign country) <u>High House Penn U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Susan Downard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Yes U.S. Army</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Daughter - Elsie M. Ziegler</u>		Address <u>Severna Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19____, to <u>1958</u> , 19____, that I last saw the deceased alive on <u>9-3-58</u> , 19____, and that death occurred at <u>7:10 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Severna Park Md 9-10-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Severna Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore 25, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, M.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9815

CERTIFICATE OF DEATH

Reg. Dist. No.

09806

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie,</u>		c. LENGTH OF STAY IN 1b <u>years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>		d. STREET ADDRESS <u>#206 Crain Highway, S.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#206 Crain Highway, S.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE REBECCA RHODES</u>		4. DATE OF DEATH Month Day Year <u>September 3, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin T. Ray</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Phelps</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>214 22 8397</u>	
17. INFORMANT <u>Mrs. Virginia Bowers</u>		Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure, Chronic</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1955</u> to <u>September 1958</u> , that I lost saw the deceased alive on <u>9-3</u> , 1958, and that death occurred at <u>10 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles R. MacDonald</u> M.D.		ADDRESS (Street, city or town, state) <u>Glen Burnie, Maryland</u>	
DATE SIGNED <u>9/4/58</u>			
PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. Singleton</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

DATE

PLACE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

HEALTH

DIET

EXERCISE

SMOKING

ALCOHOL

DRUGS

ALLERGIES

OPERATIONS

TRANSFUSIONS

IMMUNIZATIONS

OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9816

CERTIFICATE OF DEATH

09807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville RFD		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elvaton Road - Box 149		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville, RFD	
3. NAME OF DECEASED (Type or print) First Middle Last GROVER CLEVELAND RILEY		4. DATE OF DEATH Month Day Year September 23, 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1886
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (ret.)		10b. KIND OF BUSINESS OR INDUSTRY R.R. Exp.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion F. Riley		14. MOTHER'S MAIDEN NAME Amelia Fine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 714 03 4554	
17. INFORMANT Mrs. Pauline D. Riley, Same As #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs. + DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 54 , to Sept. 23, 19 58 , that I last saw the deceased alive on Sept. 21, 19 58 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Maryland DATE SIGNED 9-24-58 ACTUAL SIGNATURE Gustave H. Faubert M.D. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D. Glen Burnie, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 26/58	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		24a. REC'D BY REGISTRAR DATE SEP 26 '58	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kneal	

CERTIFICATE OF DEATH

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9817

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (RFD)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (RFD)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martell x Mt. Rd. Box 458 - Rt. 8</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Josephine Rosemary</u>				4. DATE OF DEATH Month Day Year <u>September 15 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4, 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse Aid (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jenkins Mem. Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gribbin</u>				14. MOTHER'S MAIDEN NAME <u>Anna Knell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-140312</u>		17. INFORMANT <u>Mrs. Ruth E. Thorley</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno-carcinoma pharynx</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>57</u> , to <u>Sept 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>58</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mountain Rd Pasadena Md.</u> DATE SIGNED <u>9/15/58</u>							
ACTUAL SIGNATURE <u>Arthur Lankford Jr</u>				PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR PASADENA MARYLAND</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 18, 1958</u>		<u>New Cathedral</u>		<u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Sington</u> ADDRESS <u>Glen Burnie Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Reg. Dist. No. 09809													
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sylvan Shores Annapolis</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sylvan Shores Takoma Park 1517.2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel Gen. Hosp.</u>						d. STREET ADDRESS <u>813 Davis</u>							
3. NAME OF DECEASED (Type or print) First <u>Cameron</u> Middle <u>M.</u> Last <u>Ross III</u>						4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1958</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 29 1954</u>		9. AGE (In years last birthday) <u>3 1/4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bethesda, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Cameron M Ross, Jr</u>						14. MOTHER'S MAIDEN NAME <u>Charlotte May Duerhoff Duerholm</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Cameron M. Ross, Sr. 813 Davis Ave T.P. Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Drowning</u> (c) <u>DUE TO</u> (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowning - Fell from dock into river</u>									
20c. TIME OF INJURY Hour <u>3</u> p. m. Month, Day, Year <u>Sept 7 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River</u>		20f. (City or town) <u>Sylvan Shores</u>		20g. (County) <u>A.A.</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>James I. Hudson Jr</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>James I. Hudson, Jr.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 10 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Maryland.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kline</u>						24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

MEDICAL CERTIFICATION

02

2

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [illegible]		DATE OF DEATH [illegible]	
PLACE OF DEATH [illegible]		CITY OF DEATH [illegible]	
OCCUPATION OF DECEASED [illegible]		CAUSE OF DEATH [illegible]	
MANNER OF DEATH [illegible]		MEDICAL HISTORY [illegible]	
FAMILY HISTORY [illegible]		SOCIAL HISTORY [illegible]	
PREVIOUS ILLNESS [illegible]		TREATMENT [illegible]	
POST-MORTEM EXAMINATION [illegible]		LABORATORY EXAMINATIONS [illegible]	
SIGNATURE OF MEDICAL EXAMINER [illegible]		DATE [illegible]	
SIGNATURE OF REGISTRAR [illegible]		DATE [illegible]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09810

9765

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AA General Hospital</u>		d. STREET ADDRESS <u>Glen Burnie</u> <u>Thelma K.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Agnes Scherck</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 20, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mack</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. John Scherer, Same as 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crony Choke</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>9.22.58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. To burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

69811

1. PLACE OF DEATH a. COUNTY <i>A A</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Epping Forest</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A A</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Epping Forest</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Annapolis R7D</i>		d. STREET ADDRESS <i>Annapolis R7D</i>	
3. NAME OF DECEASED (Type or print) First <i>Cliver</i> Middle <i>M. Schneider</i> Last <i></i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>20</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-7-1893</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. U. S. M. C.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Marine</i>	11. BIRTHPLACE (State or foreign country) <i>Pa</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Peter Schneider</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>I and II</i>	
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT Name <i>Helen Clair Schneider</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot wound skull</i> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <i></i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self-inflicted gun shot wound</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>9:30</i> p. m. <i>9/20/58</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. LINHARDT</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>9/20/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Sept 23 58</i>	<i>Arlington National</i>	<i>Arlington Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 23 '58</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Kneass</i>	

1

1998

9819

CERTIFICATE OF DEATH

09812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>X</u> b. COUNTY <u>None</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>71</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Grove Rd.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul Rudolph Schultz</u>		4. DATE OF DEATH Month Day Year <u>Sept. 30 1958</u>	
5. SEX <u>fm</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm Schultz</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Anna Walters - Severn</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/30</u> , 19 <u>58</u> , to <u>9/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/30</u> , 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>203 W. Maple Rd. - Glen Burnie Md.</u>	
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball, Jr.</u>		DATE SIGNED <u>9/30/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 4, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine E. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9820

CERTIFICATE OF DEATH

09813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>4y 2m 1d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyds</u> <u>15x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Simms</u> Last <u>Simms</u>			4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>76</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) -----		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>***</u>				14. MOTHER'S MAIDEN NAME -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>12/12/18</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Hospital Records</u> Address -----			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Cancer of stomach</u> (c) -----						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/21</u> , 19 <u>54</u> , to <u>9/22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/22</u> , 19 <u>58</u> , and that death occurred at <u>3:04 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>9/23/58</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>L. Benedict, M. D.</u> <u>Crownsville State Hospital Md.</u> <u>9/23/58</u> PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Snowden</u>				ADDRESS <u>Rockville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
24a. REC'D BY REGISTRAR <u>SEP 26 1958</u>				DATE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09814

9821

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> c. LENGTH OF STAY IN lb <u>45 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel Race Track</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 13x-2 d. STREET ADDRESS <u>North Laurel Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>George Smith</u>		4. DATE OF DEATH Month <u>9/28/58</u> Day <u>19</u> Year <u>19</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> <u>1/27/04</u>		9. AGE (In years last birthday) <u>54</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Race Horses Care Taker.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia.</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>											
13. FATHER'S NAME <u>SIDNEY SMITH</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)											
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Dorothy Mae Smith (wife)</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/28/58</u>						DATE SIGNED													
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial Oct 2/58</u>				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <u>Spells Cemetery</u>				22d. LOCATION (City, town, or county) <u>Near Laurel Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Logly Selby 401 W. 4th St. Laurel Md</u>								24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Krawitz</u>							
ADDRESS								DATE <u>OCT 3 '58</u>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9822
CERTIFICATE OF DEATH

Reg. Dist. No.

09815

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RITCHIE HIGHWAY				d. STREET ADDRESS RITCHIE HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OLIVIA CORBELIA SMITH				4. DATE OF DEATH SEPTEMBER 5 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 5, 1865	
9. AGE (In years last birthday) 93 yrs.		10. AGE (In years last birthday) 93 yrs.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN TUBBS				14. MOTHER'S MAIDEN NAME OLIVIA ANNE STEWART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. MAZIE S. STOLL Address 1404 CRAIN Hwy. GLEN BURNIE, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1946 , to Sept 5 , 19 58 , that I last saw the deceased alive on Sept 5 , 19 58 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 Central Ave. DATE SIGNED							
ACTUAL SIGNATURE James S. Bellhugles M.D.				DATE SIGNED 108 Central Ave.			
PHYSICIAN'S NAME (Type) James S. Bellhugles				Glen Burnie Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/8/58		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) BROOKLYN, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN O. MITCHELL & SONS				ADDRESS 1900 EUTAW Rd.		24a. REC'D BY REGISTRAR SEP 9 '58	
24b. REGISTRAR'S SIGNATURE William E. Evans							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold, Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold P.O.</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. A.A. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Coria Tucker</u>		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OF FACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-22-1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Margarets, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isiah Stansbury</u>		14. MOTHER'S MAIDEN NAME <u>Gemma Chambers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-32-5644</u>	
17. INFORMANT <u>James Tucker Arnold, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Cardiac disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Chun Tsai</u>		DATE SIGNED <u>9/30/58</u>	
EXAMINER'S NAME (Type) <u>F. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u>	22d. LOCATION (City, town, or county) (State) <u>Skidmore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Annapolis, Maryland, this _____ day of _____, 19____.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Drugs Taken

Alcohol Consumed

Tobacco Used

Other Habits

Family History

Social History

Occupational History

Travel History

Exposure to Infection

Exposure to Injury

Exposure to Poison

Exposure to Radiation

Exposure to Noise

Exposure to Heat

Exposure to Cold

Exposure to Humidity

Exposure to Air Pollution

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09817

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HEROLD HARBOR</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HEROLD HARBOR</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>M.</u> Middle <u>WHITE</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1958</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-1896</u>		9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>JAMES M. WHITE</u>								14. MOTHER'S MAIDEN NAME <u>MARY WHEATLEY</u>																
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> <u>WWI + II</u>								16. SOCIAL SECURITY NO.								17. INFORMANT <u>MRS. JAMES BENNETT</u> Address <u>MARLEY PARK, MD.</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>																								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																								
ACTUAL SIGNATURE <u>E. Linhardt</u>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>														
EXAMINER'S NAME (Type) <u>E. Linhardt</u>										DATE SIGNED <u>9/16/58</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>9-22-58</u>					22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>					22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MD.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lytle & Sons</u>										ADDRESS <u>Baltimore, Md.</u>					24a. REC'D BY REGISTRAR <u>SEP 22 1958</u>					24b. REGISTRAR'S SIGNATURE <u>Carroll S. Smith</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

1. NAME OF DECEASED <u>JOHN J. WHITE</u>		2. SEX <u>Male</u>	
3. AGE <u>45</u>		4. DATE OF BIRTH <u>1910</u>	
5. OCCUPATION <u>None</u>		6. PLACE OF BIRTH <u>None</u>	
7. MARITAL STATUS <u>Married</u>		8. EDUCATION <u>High School</u>	
9. PRESENT ADDRESS <u>1234 Main St. Baltimore, Md.</u>		10. DATE OF DEATH <u>1955</u>	
11. CAUSE OF DEATH <u>Heart Disease</u>		12. MANNER OF DEATH <u>Natural</u>	
13. SIGNATURE OF EXAMINER <u>[Signature]</u>		14. SIGNATURE OF WITNESS <u>[Signature]</u>	
15. SIGNATURE OF DECEASED <u>[Signature]</u>		16. SIGNATURE OF NEXT OF KIN <u>[Signature]</u>	

FOR STATE
HEALTH DEPT.

Item 20 Film 235 9-18-58

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9767

Reg. Dist. No.

f. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>2501 ALLENDALE Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William HENRY Williams Sr</u>				4. DATE OF DEATH Month Day Year <u>September 12 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5 1899</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspapers</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William H. Williams</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE Goodman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Gordon Williams</u>		Address <u>Adelphi, Md. 10449 Knollwood Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Drowning</u> (a), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in water from Boat</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5:00</u> <u>8/19</u> <u>58</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Water</u>		20f. (City or town) <u>Back Creek</u> (County) <u>AA</u> (State) <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles S. Petty</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/13/58</u>	
EXAMINER'S NAME (Type) <u>CHARLES S. PETTY</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>9/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>COLMAR MANOR MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Giesch Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. DATE OF DEATH
7. PLACE OF DEATH
8. CAUSE OF DEATH
9. MANNER OF DEATH
10. SIGNATURE OF DECEASED
11. SIGNATURE OF WITNESSES
12. SIGNATURE OF CLERK
13. SIGNATURE OF JUDGE
14. SIGNATURE OF SHERIFF
15. SIGNATURE OF CORONER
16. SIGNATURE OF JURY
17. SIGNATURE OF JUDGE
18. SIGNATURE OF SHERIFF
19. SIGNATURE OF CORONER
20. SIGNATURE OF JURY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09819
Item 18 Film 234 10-10-58 ams										
9824										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>			c. LENGTH OF STAY IN 1b <u>2 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u> ✓					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Evergreen Trail</u>					d. STREET ADDRESS <u>Evergreen Trail</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Melissa Scott Windsor</u>					4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1958</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>27 July 1918</u>		9. AGE (In years last birthday) <u>40</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>59</u>		
13. FATHER'S NAME <u>Lloyd Eugene Windsor</u>					14. MOTHER'S MAIDEN NAME <u>Jeanne Rowe Snyder</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Jeanne R. Windsor</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration (Accidental)</u> <u>921.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Vomiting</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) _____ (County) <u>A.A.</u> (State) _____		
21. I certify that I attended the deceased from <u>July 1958</u> to <u>9-24-58</u> 19____, that I last saw the deceased alive on <u>Sept 15</u> 19____, and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.					ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>9-24-58</u>					
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>					Severna Park Md.					
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sherbert Cemetery</u>			22d. LOCATION (City, town, or county) <u>Deale Md.</u> (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>San Annapolis Md.</u>					24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>			

2038293XV4

CERTIFICATE OF DEATH

1923

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		1878	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St. Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
Jan 15, 1923		Home		10:00 AM		98.6	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR	
J. H. Harris		Wm. H. Harris		J. H. Harris		J. H. Harris	
DATE OF REGISTRATION		PLACE OF REGISTRATION		HOURS OF REGISTRATION		TEMPERATURE	
Jan 15, 1923		Home		10:00 AM		98.6	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9825

CERTIFICATE OF DEATH

09820

Reg. Dist. No 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G Meade				c. LENGTH OF STAY IN 1b 2hrs 3 min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Michael Last Yaggi				4. DATE OF DEATH Month September Day 16 Year 1958			
5. SEX Male		6. COLOR OR RACE Cau-Mong		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 September 58	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ronald Lee Yaggi				14. MOTHER'S MAIDEN NAME Kazuko Miyagi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Father: Ronald Lee Address Yaggi, Horseshoe Mtr Court, Laurel, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 16 Sept 58 , 19 58 , to 17 Sept 58 , that I last saw the deceased alive on 16 Sept 58 , and that death occurred at 0048 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Myron J. Myers, M.D. M.D. U.S. Army Hospital, Ft Meade, Md PHYSICIAN'S NAME (Type) MYRON J. MYERS, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sept 18/58				22b. DATE THEREOF Sept 18/58			
22c. NAME OF CEMETERY OR CREMATORY St. Marys				22d. LOCATION (City, town, or county) (State) Laurel Md			
23. FUNERAL DIRECTOR'S SIGNATURE Ridgely Selby				24a. REC'D BY REGISTRAR SEP 19 58			
24b. REGISTRAR'S SIGNATURE Carlton L. Thompson							

CERTIFICATE OF DEATH

1933

NAME OF DECEASED George O. Meade		AGE 34 yrs		SEX Male		RACE White	
PLACE OF BIRTH U.S. Army Hospital		DATE OF BIRTH Sept 3, 1899		PLACE OF BIRTH Maryland		DATE OF BIRTH Sept 3, 1899	
NAME OF DECEASED John Michael		AGE 34 yrs		SEX Male		RACE White	
PLACE OF BIRTH U.S. Army Hospital		DATE OF BIRTH Sept 3, 1899		PLACE OF BIRTH Maryland		DATE OF BIRTH Sept 3, 1899	
NAME OF DECEASED Ronald Lee Yagel		AGE 34 yrs		SEX Male		RACE White	
PLACE OF BIRTH U.S. Army Hospital		DATE OF BIRTH Sept 3, 1899		PLACE OF BIRTH Maryland		DATE OF BIRTH Sept 3, 1899	
NAME OF DECEASED Kathleen M. Yagel		AGE 34 yrs		SEX Female		RACE White	
PLACE OF BIRTH U.S. Army Hospital		DATE OF BIRTH Sept 3, 1899		PLACE OF BIRTH Maryland		DATE OF BIRTH Sept 3, 1899	
NAME OF DECEASED U.S. Army Hospital		AGE 34 yrs		SEX Male		RACE White	
PLACE OF BIRTH U.S. Army Hospital		DATE OF BIRTH Sept 3, 1899		PLACE OF BIRTH Maryland		DATE OF BIRTH Sept 3, 1899	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9826

CERTIFICATE OF DEATH

Reg. Dist. No.

09821

1. PLACE OF DEATH a. COUNTY A.A. Co. MARYLAND Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hill Beach		c. LENGTH OF STAY IN 1b Rock Hill Beach, Pasadena, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Creek Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Curtis Franklin Young		4. DATE OF DEATH Sept. 20, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months 63 Days 63 Hours 63 Min. 63	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		12. KIND OF BUSINESS OR INDUSTRY American Wiping Cloth Co.	
13. BIRTHPLACE (State or foreign country) Baltimore, Md.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Carl Joseph Young		16. MOTHER'S MAIDEN NAME Bertha E. -----	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I		18. SOCIAL SECURITY NO. Alfred T. Sank, Creek Drive, Rock Hill Beach	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the rectum DUE TO 154x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 154x DUE TO (c) 154x		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac decompensation - 2 years -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 15, 1958 , to September 20, 1958 , that I last saw the deceased alive on September 20, 1958 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin		ADDRESS (Street, city or town, state) REDS BR 442 Pasadena, Md.	
PHYSICIAN'S NAME (Type) R. M. McLaughlin		DATE SIGNED Sept. 20, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24/58	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Dorsey, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR SEP 24 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Brand	

CERTIFICATE OF DEATH

1933

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

PLACE OF DEATH HOME		DATE OF DEATH A.A. 10.	
NAME OF DECEASED JACK WILLIAMSON		SEX MALE	
AGE 35		RACE WHITE	
PLACE OF BIRTH NEW YORK, N.Y.		DATE OF BIRTH NOV. 1, 1898	
OCCUPATION DRIVER		CAUSE OF DEATH HEART DISEASE	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF REGISTRAR (None)	